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MENTAL HYGIENE

VOL. XIII JANUARY, 1929 NO. 1

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The National Committee for Mental Hygiene, directly and through its affiliated state societies and local committees, works for the conservation of mental health; the reduction and prevention of mental and nervous disorders and defects; the improved care and treatment of those suffering from mental diseases; the special training and supervision of the feebleminded; and the acquisition and dissemination of reliable information on these subjects and on mental factors involved in the problems of education, industry, delinquency, dependency, and others related to the broad field of human behavior. The committee seeks to accomplish its purposes by stimulating research into the nature and causes of nervous and mental diseases and defects; conducting surveys and studies of mental-hygiene problems; applying the knowledge gained from such studies, through education and the promotion of beneficial legislation; encouraging psychiatric social work; establishing child-guidance and other mental-hygiene clinics; developing trained personnel; and coöperating with governmental and unofficial agencies whose work touches at any point the field of mental hygiene.

When one considers the large groups of people who may be benefited by organized work in mental hygiene, the importance of the movement at once becomes apparent. Such work is not only for the mentally disordered and those suffering from mental defect, but for all those who, through mental causes, are unable so to adjust themselves to their environment as to live happy and efficient lives.

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MENTAL HYGIENE

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PRINCIPLES OF A RATIONAL PENAL CODE *

SHELDON GLUECK, PH.D., LL.M.
Instructor, Department of Social Ethics, Harvard University

THE recent widespread interest on the part of individuals, institutions of learning and of less learning, research foundations, and governmental organizations in the problem of criminality is the outcome of an alleged collapse of the administration of criminal justice in the American city. Thus far, effort has taken the form of popular articles, crime surveys, commissions, conferences. But in all of the survey reports recently published, and in the work of commissions and conferences, no serious attempt seems to have been made at a basic analysis of the presuppositions and prejudices crystallized in the substantive and procedural criminal law. And no suggestions of principles for fundamental revision of the existing régime seem to have been advanced. Not even the standard-setting Cleveland survey, which remains unique in the thoroughness of its execution and the scholarliness of its interpretation, made any attempt to suggest the prolegomena to a criminal procedure more scientific than that under which society now is so ineffectively waging the struggle against crime.[1]

* Reprinted from the *Harvard Law Review*, February, 1928.

1 Dean Pound's summary of the Cleveland-survey findings, and his philosophical interpretation of the inherent and acquired difficulties of the situation in which the administration of American criminal justice now finds itself, is, however, of the utmost value in an understanding of the principal reasons for the inefficiencies and conflicting aims of the present régime.

One need hardly defend the thesis that what is required in this field is a fundamental reëxamination[1] of the foundations of criminal law and procedure in the light of what is known to-day of psychiatry, psychology, and social case-work—that rapidly growing trinity of the yet to be developed master discipline, the "science of human nature". Such a reëxamination, however, must go more deeply than the drafting of logically articulated, but questionably premised penal codes. It can certainly not be limited to "getting a law passed". It cannot be satisfied by "speeding up justice", when nobody has any clear notion of what justice is, and just why and at what link in a complicated procedural chain speed is desirable. Finally, it cannot be made by persons whose only qualification, profound as that may be, is learning in "dogmatic law", and whose minds move logically, but provincially, within the ambit of "legal reasoning". The most creative legal treatises and judicial opinions have come from scholars whose dis-

[1] The Italian penal-code commission headed by Professor Enrico Ferri, appointed September 14, 1919, was faced at the outset with the choice of making "a simple revision and technical correction of the statutes now in force", or propounding "a new and autonomous systematization of legislative norms in accord with the advance of scientific doctrines". The president of the commission said that the reason why it chose the latter alternative was "to avoid the inconveniences already experienced in Italy and abroad from attempting reforms that are fragmentary and often contradictory", and insisted that the reforms proposed "ought to respond to one general direction and one organic system". See Ferri's *Relazione sul Progetto Preliminare di Codice Penale Italiano* (Rome: "L'Universelle" Imprimerie Polyglotte, 1921), pp. 3–4, 180–81. This volume will hereinafter be referred to as the *Italian Project.* For an able discussion of this code project, see *Enrico Ferri et l'avantprojet de Code Pénal Italien de 1921,* by Fernand Collin. Brussels: Vve. F. Tarcier, 1925.

The London *Times* for November 23, 1927, reports that the draft of the Fascist penal code, prepared largely by Signor Rocco, the Fascist Minister of Justice, affirms as a basic principle the criterion which Ferri's code abandoned as unsatisfactory because unscientific. As a preliminary to enunciation of the penal philosophy of the positive school of criminology (Lombroso, Garofalo, Ferri), Professor Ferri many years ago pulled the foundation from the classical theory which bases criminal responsibility on freedom of will, substituting "social accountability" therefor. The new code, however, which appears to have every chance of adoption, is supported by Signor Rocco's statement that "there must be no modification of the principle of responsibility, which has rested for centuries on the basis of the individual capacity of understanding and will, and of consciousness and volition in human action". London *Times, supra.* For the text of the Rocco code, see *Progetto Preliminare di un Nuovo Codice Penale* (1927). See also Ferri, *Il Progetto Rocco di Codice Penale* (1927) 7 *Scuola Positiva* (N. S.), no. 11–12.

ciplined learning in the law has not blinded them to the possibilities of infusion therein of wisdom from other arts and sciences. The twentieth-century sociological school of jurisprudence expresses the movement to interrelate the social sciences, of which the law is but one. Law is no longer regarded as a self-sufficient, cabalistic discipline, isolated from the general stream of culture. We are realizing more and more that methods and attitudes from outside the realm of the formal law must be imported into the legal order as powerful catalyzers to creativity. We can no longer be content with the use of exclusively legal materials in the critique of the law.[1]

It is not easy, however, to find the means of this creative cross-fertilization, especially with regard to the penal régime. Deep-rooted fears and prejudices are embalmed in our penal law. For the purpose of focusing thought upon this problem, we set down some tentative principles for a penal code that, in the light of modern ethical, psychological-psychiatric, and sociological views, give some promise of being more rational and just than the procedure under which we are ineffectively laboring.

The basic social-ethical principle of any system of penal law should express the *raison d'être* of that system. Too often in the past has the basic principle of penal codes been implied, rather than expressed and defended, with the result that our penal statutes are full of confusions and inconsistencies, containing statutory and case-law accretions of many epochs and philosophies. We submit the following basic principle: *Society should utilize every scientific instrumentality for self-protection against destructive elements in its midst, with as little interference with the free life of its members as is consistent with such social self-protection.* This proposition is basic to any discussion of social problems. If one denies that a society should protect itself, he not only

[1] See *The Social Sciences and their Interrelations,* by William Fielding Ogburn and A. A. Goldenweiser (Boston: Houghton Mifflin Company, 1927), for abundant evidence of the recognition of the need for an assault upon the more or less artificial barriers between the sciences. A few colleges of political science and one or two law schools are beginning to recognize the possible value of systematic collaboration among the social scientists.

denies to it the fundamental right of self-preservation, but jeopardizes his own security. Only by repelling criminal attacks against itself or its members can organized society offer the peace, security, and traditional expectancy of orderliness which are indispensable to the pursuit of the affairs of life by itself and its members. One who denies this indirectly advocates his own destruction.

In this basic work of self-protection, society should utilize every available scientific instrumentality. This is dictated both by the principle of justice and that of economy. While society has a primary interest in maintaining the general security, it also has an interest in the welfare of the individual life, and a duty to use every reasonable instrumentality for the rehabilitation of its antisocial members. Even a socially harmful criminal has a right, in justice, to be treated with those instrumentalities that give him the greatest promise of self-improvement and rehabilitation.

Justice demands also that, in its work of self-protection, society interfere as little as possible with the free life of its members. If one conceives of society as a necessary instrument for the harmonious integration of the more or less conflicting desires of human beings with the demands of the general welfare, one must acknowledge that social interference should cease at the point where such integration cannot be brought about by interference. A law or procedure which, in the general opinion, unnecessarily or arbitrarily overemphasizes the social interest in the general security to the undue interference with the social and individual interests in the life and well-being of each person, is unjust, for it unnecessarily enslaves human beings.[1]

Not only justice, but economy dictates the employment of scientific devices in the work of social self-protection. It is wasteful for society to be satisfied with a continuance of the present judicial and peno-correctional régimes, because the

[1] It is much easier to formulate this general principle than to apply it in any specific instance. It cannot be denied, however, that a society which interferes substantially more with the liberty of its members than is dictated by a scientific conception of the general welfare is to that degree unjust.

large figures of recidivism[1] are an indication that the present methods are not preventing criminals from repeating their antisocial behavior.

The chief means which society has long relied upon to maintain the general security is punishment either on a retributive-expiative theory, or for the pragmatic purposes discussed below. The old argument was that punishment was necessary as a "just retribution" or requital of wickedness. No thoughtful person to-day seriously holds this theory of sublimated social vengeance, or that "expiative theory" which is the reverse of the shield of retribution. Official social institutions should not be predicated upon the destructive emotion of vengeance, which is not only the expression of an infantile way of solving a problem, but unjust and destructive of the purpose of protecting society. The official social institutions of criminal law and penal treatment should not be occupied with the criminal's expiation of his sins; that is properly the domain of religion. Society's legal institutions are concerned with the utilitarian possibilities of a punishment régime, possibilities which are founded upon the social purpose of the machinery of justice—namely, the maintenance of the general security with as little interference with the individual's rights as a human being and citizen as is necessary for the achievement of that social purpose.

[1] Almost every prison census and work on criminology refers to the problem of recidivism. See Dr. Bernard Glueck's *A Study of 608 Admissions to Sing Sing Prison*, MENTAL HYGIENE, Vol. 2, pp. 85–151, January, 1918. On the basis of his Sing Sing studies, Dr. Glueck found that 66.8 per cent of 608 consecutive admissions to Sing Sing Prison were recidivists—*i.e.*, persons who had been previously sentenced to penal institutions. (See his *First Annual Report of the Psychiatric Clinic in Collaboration with Sing Sing Prison.* New York: The National Committee for Mental Hygiene, 1917. pp. 11, 16.) In a relatively recent examination by The National Committee for Mental Hygiene of 1,288 unselected prisoners of 34 county jails and penitentiaries in New York State (exclusive of New York City) it was found that 66 per cent were repeated offenders. This figure for petty offenders (drunkards, vagrants, prostitutes, and those who have committed petty larceny) is strangely about the same as that for the more serious offenders of Sing Sing prison. "This is but in keeping with similar studies in penal and correctional institutions throughout the country, and means that we are in a large measure dealing with the same material over and over again—locking up and turning out the same individuals, and failing adequately to protect society from their depredations." *A Plan for the Custody and Training of Prisoners Serving Sentences in the County Jails in New York State.* New York, 1924. p. 16.

It is sometimes argued that it is "natural" and thus "right and proper" that we "hate the criminal" and show our hatred. But (aside from the question whether everything that is "natural" is necessarily right) much of our hate reaction toward criminals has been conditioned by education. Men used to hate the insane, and punished them accordingly. To hate acts that are socially harmful may be proper; but to base a policy of social protection upon hatred of those who commit such acts is both uneconomical and unjust. It is uneconomical because, far from the vengeful attitude having produced socially desirable results, it has failed throughout to stem the tide of recidivism.[1] It is unjust because every human being has the right to be considered as such, with his hereditary and acquired weaknesses, as well as his strengths. This is to some extent feasible with modern scientific instrumentalities; but no device yet invented can dive into the heart and mind of an individual and come up with that exact apportionment of blame and blamelessness which even a rationalized vengeance called "solemn justice" demands as a prerequisite to castigation.

The attitude we are discussing may also be conceived of as a "rationalization" of something which is psychologically more profound. To one unfamiliar with the data of psychoanalytic psychology the following analyses of this attitude will doubtless be a surprise; but upon mature and honest reflection such a reader will gradually become convinced that there is more than "a grain of truth" in these suggestions. Says Dr. William A. White, dean of American psychiatrists:

"The criminal thus becomes the handy scapegoat upon which he [the ordinary citizen] can transfer his feeling of his own tendency to sinfulness and thus by punishing the criminal he deludes himself into a feeling of righteous indignation, thus bolstering up his own self-respect and serving in this roundabout way both to restrain himself from like indulgences and to keep himself upon the path of cultural progress. The legal punishment of the criminal to-day is, in its psychology, a dramatic tragic action by which society pushes off

[1] It is a well-known fact that when punishment becomes so severe as to suggest the revenge motif rather than the idea of social protection, juries are loath to convict.

its criminal impulses upon a substitute. The principle is the same as that by which an emotion such as anger is discharged upon an inoffensive lifeless object."[1]

Discussing Spinoza's views on determinism and psychology, Dr. M. Hamblin Smith gives a similar analysis of the "righteous indignation" rationalization of man's fear and anger responses and its social crystallization into a program of punishment *qua* punishment:

"It is often said that determinism leaves practical questions exactly as they were before. Generally speaking, this statement is true. But it is not true in one important particular. All ground for blame, in the ordinary sense of that word, has been removed. This deprives the ordinary man of what he finds a great comfort. . . . We may point out that man always wants to blame others for what he finds in himself. The matter goes much deeper than the influence of the primitive instinct of vengeance. Man is always trying to get rid of something that makes him unhappy. If this something happens to be wrong, according to the ethical standards of the herd, he attempts to escape his personal responsibility for it. In punishing an offender, man is trying to get rid of a wrong which he feels is resident in himself. Hence the offender becomes a convenient scapegoat."[2]

Turning now to the utilitarian justifications of punishment, much confusion in the discussion of this subject can be avoided by referring to the influence of the *threat* of arrest, imprisonment, or execution, as the *deterrent* effect of punishment, and the influence of the memory of past punishment upon the individual punished as the *preventive* effect of punishment. The first is the psychological effect of a continuous appeal to the fear emotion in the form of a threat of enforced suffering in making "the rest of us" behave in conformity with the law; the second, the psychological effect of the recollection of past punishment in influencing the future conduct of an ex-prisoner to bring it within legal bounds.

[1] *Insanity and the Criminal Law*, by William A. White, M.D. New York: The Macmillan Company, 1923. pp. 13–17.

[2] Cited by William T. Root, Jr., in *A Psychological and Educational Survey of 1,916 Prisoners in the Western Penitentiary of Pennsylvania.* Pittsburgh: Board of Trustees of Western Penitentiary, 1927. pp. 11–12.

As to the first influence, knowledge of psychology must convince one that much of conduct can be and in fact is influenced by the threat of punishment. Fear plays an important rôle in deterring most persons from the commission of legally prohibited acts, although other motives are, of course, also operative. Since the threat of arrest and punishment is an appeal to fear, which for most persons is probably the strongest motive, it doubtless has a deterrent value. It is fallacious to argue, as many do, that because the volume of crime in proportion to the population has not diminished, or is rising (if such be the case), such a condition proves that the threat of punishment is no deterrent. No one can say how much *more* crime there would be on the part of the law-abiding public were the restraint of the threat of punishment removed. During the Boston police strike, for example, not all of the increased crime was due to "imported criminals" or local habitual criminals. Some of it was probably brought about by persons on the brink of criminality who needed just that removal of the threat of apprehension and punishment to push them over into the criminal ranks. The same phenomenon is observable after every great public catastrophe when among those who steal from the bodies of dead and wounded there are a number of people who formerly were law-abiding, but who commit crimes upon the removal of organized restraint in the post-catastrophic confusion.

But though the threat of punishment has some deterrent value, it must be pointed out that a scientific system of penal law, taking the point of view of modern psychiatry, would not, in any real sense, deprive society of whatever deterrent effect such threat might have. The modern psychiatric school of criminology does not ask that we pass by unnoticed the acts of criminal aggression committed by individuals, and thus break down the defensive breastworks of the threat of punishment. Under the régime proposed herein,[1] for example, antisocial persons would still be deprived of their liberty. Nay more, it may justly be claimed that the proposed procedure of scientific individualization would have a greater deterrent effect than does the present mechanized and bar-

[1] See page 25 of the present article.

gaining procedure. Under the existing system, prospective criminals know in advance the chances of probation and, essentially, the length of imprisonment as related to contemplated crimes; and they know that with the mechanically applied rules as to "time off for good behavior", parole as an automatic "reward" after the minimum limit of a sentence euphoniously designated "indeterminate" has been reached, and similar unscientific devices, they will be given their freedom *regardless of their improvement or further deterioration.* This is so because the present system bases penal treatment on a single or a few isolated acts of a person rather than upon knowledge of the personality and motivations of the offender and his social background.

With the emphasis shifted, as is proposed, from the isolated criminal act to the personality of the offender—his potentialities for good and evil, his response to treatment, and so on—and his social setting, a prospective wrongdoer will not be able to estimate in advance the length of his incarceration, on the basis of the seriousness of the contemplated offense as set down in the statute books or the mechanized activities of judges and parole boards. For an offense relatively venial in itself, it is conceivable that a socially dangerous *personality* may remain incarcerated for life; and for one relatively serious, it is likewise conceivable that a person who has profited by institutional or extramural treatment and gives reasonable scientific promise of permanent rehabilitation will be given his liberty after a comparatively short period. The vital element of the possibility of lifelong incarceration, if the individual is shown by scientific investigation to require it, may reasonably be expected to reinforce the natural deterrent effect of the threat of punishment.[1]

[1] Another advantage of a change in basic principle of the penal system along the lines proposed herein is suggested by the following words of Professor Ferri: "Since [under the present régime] the judges have before them a man and not an objective fact, a contrast often arises in their consciences and in their sentences between the law and the human reality, and their judgments do not carry public approval because deemed too rigorous or too inadequate." *Italian Project,* pp. 183–84. This public attitude is founded on the old notion that the sentence is the payment to society of an amount of suffering precisely proportionate to the amount of harmfulness of the crime, something in itself impossible of measurement.

The principle of peno-correctional treatment of the offending personality rather

Considering now the second question—the prevention of further wrongdoing by the recollection of the punishment for the last—here again we cannot go along with most of the modern radicals in criminology. It cannot be seriously denied that the fear of the repetition of a painful experience of the past plays an important rôle in the guidance of conduct. Such anticipation of a painful reaction to a certain form of behavior (founded upon the psychological phenomenon of memory or whatever its neurological correlate may be) acts as a powerful influencer of conduct. The rôle of punishment and reward as determinants of behavior is clear in the laboratory when one deals experimentally with animals. Punishment is recognized also as an instrument for influencing the conduct of children and adults. It is daily used in the affairs of life and in penal institutions to influence conduct.

It is submitted, however, that punishment is an instrumentality that should not be used blindly, but by trained scientists, and only where "indicated", as the physicians would say. Moreover, punishment is but one of numerous "medicines" or devices that are more and more being put at the disposal of trained experts. It, as well as these other instrumentalities, should be utilized only after careful examination of the individual criminal has demonstrated his peculiar needs. It is the conviction of psychologists and psychiatrists that the emotion of fear is not the only motive of conduct, lawful or unlawful. It is certainly not the highest motive to appeal to, and not necessarily the most effective. It may well be that in the excitement of a criminal act the memory of the former suffering is beclouded; that in particular individuals (whether they are mentally "abnormal" or not) such former punishment has had little, if any, lasting effect; that the appeal to other motives promises to "build in" a more lasting change of character and habit than the appeal to fear alone or primarily; that in certain individuals, empha-

than of punishment supposedly commensurate to the precise gravity of an act will gradually become prevalent. Indeed, the widespread use of probation and the juvenile court is already transforming the public attitude toward the entire problem. We may expect the gradual replacement of the bargaining attitude by one in which length of deprivation of liberty will be recognized to depend upon the response of the offender to treatment.

sis of the appeal to fear is the worst possible method of treatment, resulting, as it so often does with juvenile delinquents, in the building up of strong defensive or compensatory bulwarks of defiance, distrust, grudgefulness, or "low cunning", which in turn lead to further misconduct.

Our discussion indicates, then, that to continue in operation a penal system grounded largely upon the appeal to fear is unjust and uneconomical; but that a rational approach to the problems of crime and its treatment would not ignore the possible utility of punishment either as a deterrent or a preventive. It seeks merely to evaluate it according to its true worth, and to control it in accordance with a well-rounded preventive-therapeutic program. Moreover, such a view of the rôle of the appeal to the emotion of fear promises not only to retain whatever present effectiveness there may be in punishment, as a preventive or deterrent, but to increase it.

As long as the legal order confined itself to a reliance upon fear as the principal instrument for the protection of society against criminal aggression, there was not much need for scientific individualization of peno-correctional treatment. The criminal law defined the crimes, the penal statutes set down for each offense the precise dosage of punishment fatuously believed to "fit the crime", and the judge mechanically sentenced convicted persons on the basis of this schedule of punishments. But with the recognition of the futility of that system because of the complex mental and social factors which enter into the commission or failure to commit crimes, individualization of treatment must be recognized as indispensable. Effective individualization must be based upon as complete an understanding of each offender as modern science will permit. Hence psychiatry, psychology, and social case-work—not to mention those disciplines more remotely concerned with the problems of human motivation and behavior—must be drawn into the program for administering criminal justice. And this is true not alone in those cases in which a definite mental disorder is present, but in the general run of cases. For only by recognition of the motives behind and the social setting of criminal conduct can the treatment prescribed by the judge be intelligently calculated to protect society, through the rehabilitation of those who respond to

treatment and the permanent isolation of those who do not so react.

Only through the systematic assistance of psychiatrists, psychologists, and social investigators can even the existing individualizing instrumentalities—probation, the indeterminate sentence, parole, the juvenile court—be effectively utilized. Thus, "probation" in some jurisdictions means the evil practice of releasing almost every first offender and many a dangerous repeater "to give him another chance". The hoped-for rehabilitation is ostensibly to be brought about by some miracle. For in such jurisdictions no effort whatsoever is made either in the way of examination into the social-psychiatric conditions of the offender to determine his fitness for probation, or in the way of constructive supervision during the probation period. Thus an instrumentality the very creation of which was due to recognition of the importance of individualization is used mechanically, perfunctorily, and in some cases even corruptly. Probation in a few jurisdictions,[1] however, is based on careful, individualized examination and treatment, in which psychiatrists, psychologists, and social workers are the interpretive agencies, while the judge represents the tempering wisdom of the legally experienced magistrate. The same distinctions could be made between so-called "indeterminate sentences", "parole", and "juvenile courts", and the genuine devices whose titles have thus been wrongly preëmpted. In a word, individualization is necessary on the part of the court and other institutions dealing with the offender; and effective individualization is not based on guesswork, mechanical routine, "hunches", political considerations, or even (as so many judges seem to think) on past criminal record alone. It must rest on a scientific recognition and evaluation of those mental and social factors involved in the criminal situation which make each crime a unique event and each criminal a unique personality.

[1] As indicative of what probation ought to be and of its tremendous importance in the protection of society, through rehabilitation of promising offenders, the reader should consult Edwin J. Cooley's *Probation and Delinquency* (New York: Catholic Charities of the Diocese of New York, 1927). Notice particularly the subtitle: *The Study and Treatment of the Individual Delinquent.* See also, Miriam Van Waters' *Youth in Conflict.* New York: Republic Publishing Company, 1925.

The objection has been made against the consistent use of psychiatry, psychology, and social case-work in the administration of criminal justice that these instrumentalities are still in a highly experimental and formative state and that experts representing these disciplines frequently disagree when asked to give opinions. The principle is self-evident that in a wise legal order we should proceed cautiously in absorbing methods or attitudes from outside of the law. But it must be said that the disagreement between experts has been "greatly exaggerated". On fundamental symptomatology of the various mental and behavior disorders most psychiatrists are agreed. On basic mental "mechanisms" [1] many of them are coming more and more to agree. True, there are some real differences of opinion on questions of *theory,* on attempts to account for the phenomena observed. But this is a healthy sign of a growing discipline; it is not absent in the law itself. There is also disagreement as to the effectiveness of various methods of therapy, which is likewise a sign of vitality. Again, in the realm of psychology, standardized intelligence tests of various kinds are admittedly far from perfect and are undergoing continuous improvement on the basis of experimentation. Yet their use is becoming more and more widespread if also more critical. Further, a complete, perfectly logical set of principles of social case-work has not yet been developed; but a body of wisdom, based on experience, is gradually crystallizing, and scientific method is little by little being infused into social case-work.[2] The imperfection in social-service technique did not prevent the rapid spread of the movement to substitute "constructive social work" for indiscriminate, mass-treating, wasteful, pauperizing "charity". Though the instruments for con-

[1] See *Mechanisms of Character Formation,* by William A. White, M.D. (New York: The Macmillan Company, 1916); *The Psychology of Insanity,* by Bernard Hart, M.D. (Cambridge [Eng.] University Press, 1923); and *Mental Disorders in Medicolegal Relations,* by A. M. Barrett, M.D., in *Legal Medicine and Toxicology,* edited by Frederick Peterson, W. S. Haines, and R. W. Webster. (Philadelphia: W. B. Saunders Company, 1923).

[2] See, for example, Mary E. Richmond's *Social Diagnosis* (New York: Russell Sage Foundation, 1917) and *What Is Social Case Work?* (New York: Russell Sage Foundation, 1922). Consult Cooley (*op. cit.*) for striking illustrations of the possibilities of constructive social case-work methods in the service of the court.

structive social work are still far from ideally suitable to the purpose, nobody would seriously propose the return to the old methods of almsgiving. In the field of criminal justice, society has experimented for many years with mass-treatment, unscientific methods. Is it not time to make a serious effort at experimentation with the more promising techniques? Any system of diagnosis and treatment of the individual delinquent based on a responsible application of such scientific instrumentalities as exist, few and imperfect as these may be, is superior to a practice which treats human acts *in vacuo,* and human beings mechanically, perfunctorily, and in the mass, on the basis of impossible rules set down by the legislature in advance of the events to which they are to be applied by perplexed judges.

Assuming the necessity of individualization, at what stage in the procedure of criminal justice shall it be made and by what legal agency? The work of individualization of one kind or another may, of course, be attempted at various stages and by differing means. The district attorney may crudely "individualize" as to types of cases he is going to stress in prosecution out of a mass of cases. Again, definitions in the substantive criminal law itself, such as the historical distinction between murder and manslaughter,[1] distinctions between voluntary and involuntary manslaughter, or between burglary and larceny, represent crude judicial and legislative categorizations of types of somewhat analogous criminal acts, on the ground that the individual acts differ in degree of seriousness. So also the breaking up of crimes into rather detailed "degrees", which was so common a phenomenon in American codes and statutes in the nineteenth century and which is still a characteristic, represents a later and less crude process of legislative individualization in the trial and punishment of varieties of a similar type of criminal act rather than of classes of criminal.[2] Such code or statutory provisions are

[1] See authorities collected in *Selection of Cases on Criminal Law,* by Francis B. Sayre. New York: Lawyer's Coöperative Publishing Company, 1927. pp. 767 *et seq.*

[2] Such, for example, are the distinctions in varieties of arson found in the New York Penal Law, §§ 221–23, dividing the crime into three degrees dependent largely on the type of structure burned and whether the burning was by day or night; the familiar practice of breaking up burglary into degrees, depending

customarily accompanied by stipulations as to fixed length and type of punishment, leaving the trial judge, or (in states where the jury has anything to do with fixing the punishment) the jury, relatively little discretion as to penal treatment. These are very crude "individualizations" of various classes of offenses by the legislature. Within such crime categories, however, there is no distinction made between individual delinquents; all offenders committing the same crime are punishable equally.

The "indeterminate sentence" movement, which began late in the nineteenth century as a recognition of the need of individualization of punishment, has in practice had but little effect upon these fixed provisions regarding punishment or upon the attitude which inspired them. For, in the first place, not all states have indeterminate sentences; secondly, indeterminate-sentence provisions apply in most jurisdictions only to specified types of crime or to persons within specified age limits; and thirdly, the aims of the proponents of the indeterminate sentence have frequently been defeated on the one hand by judges imposing sentences which practically make the minimum limit identical with the maximum (as a sentence, say, of from twenty-four years and six months to twenty-five years), and, on the other, by parole boards automatically releasing prisoners after the minimum limit of the sentence has been served. We may fairly say, then, that although crude attempts have been made at individualization of penal treatment on the basis of type of crime, and by use of the so-called "indeterminate sentence", the mass-treatment method of dealing with offenders, founded on legislative prescription in advance of detailed rules for the guidance of the judiciary, is, by and large, still in vogue in the American criminal court.

The provision for pleas in mitigation or aggravation of pun-

upon whether or not the entry is accompanied by one or more of the common-law requisites of burglary or not; the division of murder and manslaughter into degrees based on such mental and other accompaniments of the homicide as whether or not the act was done with "deliberately premeditated malice aforethought" (Mass. Gen. Laws [1921], c. 265, § 1), whether or not is was committed in the perpetration or attempted perpetration of specified other crimes, such as rape, arson, robbery, or burglary, whether the means were poison (Pa. Act of April 22, 1794, § 2), or interference with railroad tracks (N. Y. Penal Law, § 1044).

ishment after conviction, but prior to sentence, represents another stage and method of individualization of penal treatment. This is, however, also a crude and unreliable instrument, the appeal to judicial discretion consisting, as it frequently does, of one-sided emotional or irrelevant pleas to the judge rather than unbiased reports founded on scientific examination. Then there is the crude, mechanical, unimaginative individualization of the judge who has made up his mind in advance to impose heavy sentences on offenders against certain laws, or on second offenders, or to place only offenders against certain legislation on probation, and that regardless of how often they have already failed under such extramural treatment in the past, and of how promising of redemption offenders against other laws might be.

As to all these methods of "separating the sheep from the goats", one may safely say that they do not constitute efficient instruments of that scientific individualization which we found to be the *sine qua non* to economical as well as just administration of criminal law. Legislative prescription in advance of detailed degrees of offenses is individualization of acts and not of human beings, and is, therefore, bound to be inefficient. Judicial "individualization", without adequate scientific facilities in aid of the court, is bound to deteriorate into a mechanical process of application of certain rules of thumb or of implied or expressed prejudices.

Yet it is along the lines of an even more detailed legislative prescription of rules to be applied by trial courts in individualizing punishment of future criminals than exists in America to-day that Professor Enrico Ferri's penal code commission has drafted its basic provision. American experience, however, both with the detailed definitions of the pre-indeterminate-sentence era, and with the indeterminate sentence as applied by judges, would suggest that this setting down of detailed rules of individualization by the legislature in advance, for the guidance of the bench in the imposition of sentence, is not the best road out of the jungle of the present inefficient judicio-penal practice.

Ferri's commission recommends that a schedule of "conditions of dangerousness" and "conditions of less dangerousness" be adopted for the guidance of judges in indi-

vidualizing punishment. The basic criterion of his scholarly project for an Italian penal code is "the principle of the dangerousness of the offender".[1] The penal code and the penal and correctional institutions take this principle as their point of departure. This must be admitted to be a great stride in advance, when one compares it with the basis of our criminal law as expounded by Dean Pound:

"Historically, our substantive criminal law is based upon a theory of punishing the vicious will. It postulates a free agent confronted with a choice between doing right and doing wrong and choosing freely to do wrong. It assumes that the social interest in the general security and the social interest in the general morals are to be maintained by imposing upon him a penalty corresponding exactly to the gravity of his offense."[2]

This existing criminal law stresses but one act of the offender, without going into the causes of that act or considering other acts or the personality of the actor. Since it thus treats *a symptom* instead of regarding the entire symptom complex and its causes, it is bound to be almost as ineffective as a medical régime which prescribes for a single symptom, not troubling with its relation to other symptoms or with the causes of the symptoms.

But in the light of what was said above, it must be obvious that to found a new penal code on the sole principle of the dangerousness of the offender,[3] which condition is to be arrived at by judicial application of a legislative schedule of "conditions of dangerousness" and those of "less dangerousness", is open to objections. First, it emphasizes a single feature (although it improves upon existing practice in that that feature is a more or less lasting *condition* rather than an individual act) and, secondly, it employs in the work of individualization an instrument that has already been shown to be inadequate.

As to the first point—which is incidental to the main discussion at this stage—if the offender is "dangerous", is not that

1 *Italian Project*, pp. 7, 49 *et seq.*, 153, 183 *et seq.*, 229 *et seq.*, 342.

2 Introduction to Sayre (*op. cit.*), pp. xxxvi–xxxvii.

3 The other principle Ferri employs, "social defense", while broader, is still subject to the above criticism, when used as Ferri proposes.

but one feature of his personality make-up? To look only at his dangerousness is both unjust and unscientific. In overemphasizing the social interest in the general security to the underemphasis of the social interest in the individual life, it is unjust. The easiest way to dispose of criminals, when one stresses their social dangerousness, is to execute them all. But such a principle, standing alone, does not recognize the social justice of constructive rehabilitative work with delinquents on the basis of individual case study and need. It is uneconomical, for it does not realize that the most efficient way of coping with the problem, in the long run, is this same constructive rehabilitative effort with the individual delinquent, on the basis of scientific understanding. For while executed criminals do not destroy, neither do they build; and this latter possibility is certainly not to be ignored merely because the traditional, mechanical, punitive régime has failed to reform many criminals. Besides, if we are ever going to learn anything about criminal motivation, it is short-sighted to destroy our "laboratory material" without study.

It is true that, as to the penal organization, Ferri agrees with the soundest American thought on the problem, when he says: "In place of the traditional system of prison penalties for a fixed period, there must be substituted segregation for a period relatively or absolutely unlimited, while the necessary guarantees for individual rights are secured."[1] Nevertheless, by stressing the dangerousness of the offender, Ferri unduly underemphasizes the rehabilitative possibilities of the offender.

We would therefore substitute for Ferri's basic criterion the following: *The legal and institutional provisions for the protection of society must be based not so much upon the gravity of the particular act for which an offender happens to be tried as upon his personality—that is, upon his dangerousness,*[2] *his mental and social history, his personal assets, and his responsiveness to peno-correctional treatment.*

[1] *Italian Project*, pp. 15, 192.

[2] It is quite true, as Ferri points out, that the emphasis of the dangerousness of the offender becomes of vital significance in treating of the law of attempts. It is conceivable, for example, that one who attempts a crime, but does not for some reason bring about its completion may be a much more dangerous person than another whose attempt has ripened into a completed act. Both would ordinarily

This criterion takes account of the well known fact that a relatively innocuous act may happen to be, and not infrequently is, committed by one who fundamentally is socially dangerous, while a relatively serious offense (even murder)[1] may be committed by one who fundamentally is no longer socially dangerous. But it also takes account of the fact that when we speak of "personality", rather than "crime" or "act", we are dealing with a developing, dynamic phenomenon rather than a static fact, a complex energy system of which dangerousness at the time of conviction is but one symptom.

The second point of criticism of Ferri's system is more serious. It is doubtful whether any scheme of individualization based on a schedule of minute rules set down by the legislature to govern judges in future cases can be successful. This can no more be done by the legislature as to a person's character than it can (as at present attempted) as to single acts. The legislature cannot possibly conceive in advance the subtle *nuances* that distinguish different offenders from each other, nor the types or lengths of treatment required by various individuals. What the legislature can do is to set down certain broad penological standards and leave to trained judges, psychiatrists, and psychologists, forming a quasi-judicial treatment body, the application of those standards in the individual case.

An examination of the details of Ferri's scheme will indicate that this criticism is sound. In accordance with his policy of emphasizing the dangerousness of the offender and at the same time providing for "necessary guarantees" of individual rights, Ferri furnishes an elaborate, narrowly defined schedule of "conditions of dangerousness" and "con-

be guilty of some offense at present, but the former would be punishable far less—*i.e.*, only for an attempt, the latter for the more serious, completed crime. But the question is, Shall dangerousness be the sole criterion, and shall it be provided for in the substantive law, or by its inclusion among the "conditions of dangerousness", or shall its recognition, together with the many other factors disclosed by scientific examination of the individual case, be by a "treatment board" with wide administrative discretion? See page 25.

[1] Mrs. Jessie D. Hodder, one of the foremost prison administrators in the country, has on several occasions said that the inmates of her institution (The Massachusetts Reformatory for Women) who make the least trouble and who are the most trustworthy are those who have committed certain types of homicides.

ditions of less dangerousness", to be prescribed by the code in advance and to be applied by judges as a basis for computation of the type and length of the individual convict's incarceration. At the same time, he stresses the necessity of "segregation for a period relatively or absolutely unlimited". The "degree of dangerousness" is to "be determined according to the gravity and modalities of the offense, the determining motives, and the personality of the offender".[1]

[1] The following are the "circumstances which indicate a greater dangerousness in the offender":

"(1) Dissoluteness or dishonesty of prior personal, family, or social life; (2) Prior judicial and penal record; (3) Abnormal organic and mental conditions before, during, and after the offense, which do not constitute mental infirmity and which reveal criminal tendencies; (4) Precocity in committing a grave offense; (5) Having acted through ignoble or trivial motives; (6) Family and social relationship with the injured or damaged party; (7) Deliberate preparation of the offense; (8) Time, place, instruments, manner of execution of the offense, when these have rendered more difficult the defense by the injured or damaged party or indicate a greater moral insensibility in the offender; (9) The execution of the offense by means of ambush or stratagem or through the commission of other offenses or by abusing the aid of minors, the deficient, the unsound of mind, the alcoholic, or by employing the assistance of other offenders; (10) The execution of the offense during a public or private calamity or a common danger; (11) Having acted by prearranged complicity with others; (12) Abuse of trust in public or private matters or malicious violation of special duties; (13) Execution of the offense on things confided to the public good faith or kept in public offices or destined for public utility, defense, or reverence; (14) Abuse of personal conditions of inferiority in the injured party or of circumstances unfavorable to him; (15) Having aggravated the consequences of the offense or having through the same act and not by mere accident damaged or injured more than one person, or having through one and the same crime violated various provisions of law, or the same provision of law at various times, by acts carrying out one and the same resolve; (16) Blameworthy conduct after the offense towards the injured or damaged party or his relations, the person present at the time of the offense, or those who gathered at the time of the offense; (17) In offenses by imprudence (negligence) having caused the damage in circumstances which made it very probable and easy to foresee." *Italian Project*, pp. 153–54, 342–43.

The following circumstances are presumed to indicate "less dangerousness in the offender":

"(1) Honesty of prior personal, family, and social life; (2) Having acted from excusable motives or motives of public interest; (3) Having acted in a state of excusable passion or of emotion through intense grief or fear or impulse of anger unjustly provoked by others; (4) Having yielded to a special and transitory opportunity or to exceptional and excusable personal or family conditions; (5) Having acted in a state of drunkenness or other form of intoxication not to be foreseen by the offender, through transitory conditions of health or through unknown material circumstances; (6) Having acted through suggestion coming from a turbulent crowd; (7) Having used, spontaneously and

After a perusal of the items quoted in the footnote, it must be admitted that Professor Ferri and his colleagues have evidenced an enviable ingenuity in analyzing and defining the conditions of "dangerousness" and "less dangerousness" to be used as a schedule of individualization by judges. It will be noticed, however, that practically all of the "circumstances" listed are those mental and physical accompaniments of the criminal act itself which to-day are taken into account in definitions distinguishing degrees of crimes in American penal statutes, or as conditions in aggravation or mitigation of sentence, or by some judges in determining fitness for probation, by some prison officials in dealing with prisoners within the institution, by some parole boards in considering their release on parole;[1] and it is a serious question whether more is not lost than gained by removing the application of such criteria from the discretion of the last-named agencies and putting the criteria into the code to be applied by judges. For example, to the extent that it substitutes the application of criteria of dangerousness and less dangerousness *at the time of original sentence* for application of similar criteria at a later stage, the procedure provided for is inferior to that of the better parole boards. How can a judge possibly know in advance how long it will take to rehabilitate a person or even what type of institutional or extramural régime is required, without a provision for observation of the progress of treatment, and for the trial-and-error method of continuous modification of treatment in the light of results?[2] In Ferri's

immediately after having committed the offense, all exertion to diminish the consequences or to make good the damage even in part, if it be done with sacrifice of one's own economic condition; (8) Having in repentance confessed the offense not yet discovered or before being interrogated by the judge, or having in repentance presented oneself to the authorities immediately after the offense." *Italian Project*, pp. 154, 344–45.

[1] The schedules of "dangerousness" and "less dangerousness" are further complicated by exceptions and special provisions. Thus Chapter III, Art. 74, provides that "the judge shall apply the sanction set forth for each offense within the limits established by the law and according to the criteria of Art. 20" (see note 1, page 20), with certain elaborate exceptions.

[2] While provision is made for "conditional condemnation" (analogous to suspension of execution of sentence), and "judicial pardon", and while at varying periods application may be made by inmates to the judge for "conditional release" (parole), still, as to these functions as well as the original determination of the length of incarceration, Ferri sets down in advance a

scheme not only are the criteria solely those of "dangerousness", but the prisoner is permanently labeled in advance of treatment.

Such detailed legislative prescription of criteria to be judicially applied to individual cases constitutes a peculiarly unsatisfactory and confusing solution of the dilemma of which judicial discretion is one horn and detailed legislative prescription the other. Subsequent articles of the code only increase the confusion. They provide for the judicial application of the "sanctions" [1] in a manner that would transform

sort of penal mathematic by which the judge is more or less mechanically bound. Thus, Art. 83 provides: "The person sentenced to simple detention, to the workhouse, or agricultural colony for minors, or to simple or rigorous temporary segregation for a minimum not less than three years, may, after serving such period as corresponds to one-half of the difference between the minimum and the maximum, and at least two-thirds where he be an habitual offender, apply for release on condition. The convicted person who has been sentenced for one offense only and is not a recidivist and who has been placed [by the penal institution] in the category *best*, may apply for conditional release after he has served a period corresponding to one-third of the difference between the minimum and the maximum. The person sentenced to rigorous segregation for a period absolutely unlimited for an ordinary offense may apply for release on condition after twenty years; the habitual offender after twenty-four [note the arbitrary precision] years; the social-political offender after ten years." *Italian Project*, pp. 165, 365. Other articles provide for application for release from various types of institutions to be made not before nine and three years, respectively; and give the judge power "to shorten by not more than one-third" the various terms provided for, after considering the mode of the offense and the personality of the offender.

[1] Ferri's code provides an elaborate set of punishments ("sanctions") which must be taken into account by judges in connection with the conditions of dangerousness and "less dangerousness", thus further complicating the process of individualization. For *ordinary offenses by majors* over eighteen: The mulct (a species of fine); local relegation (prohibition from residence in the place of the offense for from three months to three years); confinement (compulsion to reside in the commune named in the sentence, which must be "distant not less than 100 kilometres" from that where the offense occurred, where the injured party resides, and from the offender's residence); obligatory day labor (in workhouse or agriculture colony, without night detention, for from one month to two years); simple segregation in workhouse or agricultural colony (with compulsory industrial or agricultural day labor and night isolation, for from three months to fifteen years, the type of labor to conform to "the previous life and aptitudes for labor" of the convict); rigorous segregation in "an establishment of seclusion" (with compulsory day labor and night isolation for from three to twenty years, or for an indeterminate period, but not less than ten years, if "temporary", and for life if "perpetual"). For *social-political offenses by majors*: General relegation (banishment from Italian territory for from three months to ten years); simple detention ("isolation during the night

the judge into a computer of his own sum of discretion in different types of cases.[1]

The details given in the footnotes abundantly indicate the mechanical nature of the individualization provided for. They are quite on a parity with the traditional practice in the

and, on request of the prisoner, also during the day, in a special establishment'' for from one month to ten years, the prisoner being at liberty to choose one of the forms of labor provided and to have other privileges); rigorous detention (which is indeterminate for from two to fifteen years, but may also be for not less than ten years). For *juvenile offenders*: Supervised freedom, professional correctional school or schoolship, workhouse or agricultural colony for minors, house of custody. For *majors in a state of ''mental infirmity''*: House of custody (night isolation with compulsory industrial or agricultural day labor, when possible, for at least one year, ''under the direction of a physician expert in criminal anthropology''); criminal insane asylum (same régime for at least three years); special labor colony (for alcoholics and ''others infirm of mind''; régime of ''simple'' or ''rigorous'' segregation ''for a period equal to that of the simple or rigorous segregation applied for the offense committed''). *''Complementary sanctions''* (where they do not constitute sanctions standing alone): Special publication of the sentence, suspension from exercise of trade or profession, interdiction from public office, expulsion of foreigner, ''caution for good behavior'' (depositing money or mortgage conditioned upon good behavior within probationary period of from two to five years). *Italian Project*, pp. 158–61, 348–52.

[1] These provisions completely demonstrate the underlying weakness of the Ferri proposal for individualization of punishment:

''If there occurs only one circumstance of greater dangerousness, the judge shall apply the sanction in a measure not less than half between the minimum and the maximum set forth for the offense committed by the accused.

''If there concur more than one circumstance of greater dangerousness, the judge shall apply the maximum of the sanction and shall be empowered to exceed it, but not beyond one-third.

''If the circumstances of greater dangerousness be exceptionally grave, the judge shall be empowered to apply the sanction of the next grade of severity.'' *Italian Project*, pp. 163, 354.

Articles 76 and 77 similarly set down detailed directions for a perplexed judge's penal arithmetic:

''If there occurs only one circumstance of less dangerousness, the judge shall apply the sanction in a measure less than half between the minimum and the maximum.

''If there concur more than one circumstance of less dangerousness, the judge shall apply the minimum of the sanction and shall be empowered to lower it, but not beyond one-third.

''If the circumstances of less dangerousness be exceptionally important, the judge shall be empowered to apply the sanction which is immediately inferior in gravity or else the judicial pardon according to Art. 82.

''If there occur together circumstances of greater dangerousness and circumstances of less dangerousness, the judge shall establish which are prevalent, in order to graduate the dangerousness of the accused and to apply . . . the sanction best adapted to his personality.'' *Italian Project*, pp. 164, 354.

criminal law which Dean Pound has criticized as based on an erroneous assumption.[1] While ostensibly reforming this situation, what does Ferri's scheme propose but the substitution of minute rules, mechanically to be applied by judges, the difference being that now, instead of the legislature measuring the exact gravity of the *offense* in advance, it is provided that it measure the exact dangerousness of every type of *offender* in advance. The practice is so mechanical and complicated in its conception that one has a picture of a judge checking up whether, say, "circumstances of greater dangerousness", numbered 1, 3, 7, and 14, and "circumstances of less dangerousness", numbered 5, 7, and 8 are applicable to a defendant before him, ascertaining which of the numerous "sanctions" or combinations thereof are pertinent, then using a computing machine to figure out just how much incarceration the so-called "unlimited" sentence really calls for. Both in making such provisions to be used at the time of sentence in a judicial computation of the length of incarceration[2] and in setting down a schedule of periods of time before which prisoners may not apply for conditional release, the purpose of individualized treatment is largely defeated.

This discussion brings us to the conviction that instead of the penal code setting down in advance, and in great detail, rules of "dangerousness" and "less dangerousness", numerous "sanctions", and mathematical formulæ for figuring out sentences and determining the length of incarceration and time for release from custody on the basis of such rules—all this practice to be resorted to by a trial judge—we must seek some instrumentality which will retain the essence as well as the name of individualization. But this does not mean that to provide for true individualization the treatment of the offender must be left to judges or other officials wholly without guidance and without control as to the length or nature of that treatment. A more promising method out of the dilemma than the Italian must probably be based upon four principles which should underlie individualizing criminal procedure:

[1] See page 17.

[2] The determination, in advance, of how long the antisocial patient will be confined in the peno-correctional hospital!

1. The treatment (sentence-imposing) feature of the proceedings must be sharply differentiated from the guilt-finding phase.

3. The decision as to treatment must be made by a board or tribunal specially qualified in the interpretation and evaluation of psychiatric, psychological, and sociologic data.

3. The treatment must be modifiable in the light of scientific reports of progress.

4. The rights of the individual must be safeguarded against possible arbitrariness or other unlawful action on the part of the treatment tribunal.

As to the first point, although it has long been urged by psychiatrists, it was not until the Ninth International Prison Congress of London, in 1925, that the following resolution was adopted, and that, too, "by acclamation":

"The trial ought to be divided into two parts: In the first the examination and decision as to . . . guilt should take place; in the second one the punishment should be discussed and fixed. From this part the public and the injured party should be excluded."[1]

This resolution expresses the general recognition that while the public may be concerned with the trial proceedings, the inquiries pertaining to treatment should be of a scientific, nonsensational nature not deliberately accommodated, as so many modern trials are, to the greedy appetites of "yellow journalism".

The second principle has abundant reason to support it. While a legally trained judge can act as an impartial referee during a technical trial, ruling upon the exclusion or inclusion of evidence, giving a legally unimpeachable charge to the jury, and performing similar functions, his education and habit of mind have not qualified him for the more difficult task of determining the type of treatment best suited to the individual delinquent on the basis of reports of scientific investigations. It would, therefore, seem that the work of the ordinary criminal court should cease with the finding of guilt or innocence. Recognition of the illogical and unscientific pres-

[1] Proceedings of the Ninth International Penitentiary Congress held in London, August, 1925. Edited by the secretary-general of the Congress, Sir Jan Simon van der Aa. Bern: Bureau of the International Prison Commission, 1927. p. 293.

ent procedure led us to propose the establishment of a "socio-penal commission"[1] or treatment board to be composed, say, of a psychiatrist or psychologist, a sociologist, and a lawyer. Such a tribunal would begin to function beyond the point where the substantive and procedural criminal law has prepared the case for the imposition of sentence. The primary duty of such a board would be to determine the psychiatric, social, or peno-correctional treatment appropriate to the individual delinquent, as well as its duration. But such treatment and its duration would, in accordance with the general essence of the treatment-board idea, have to be extremely flexible. This treatment tribunal would perform its functions on the basis of psychiatric, psychological, and social reports of the investigations of each delinquent.

The third principle of wise individualization—modifiability of the length and type of treatment in the light of progress thereunder—is dictated by the logic of the foregoing. For a

[1] "The jury could still pass upon the mental element of the crime—the *mens rea*; but the work of scientific determination of the *peno-correctional consequences of conviction* by a jury would be lodged in a skilled, administrative board specially qualified for such a task." (*Mental Disorder and the Criminal Law*, by Sheldon Glueck. Boston: Little, Brown, and Company, 1925. p. 486.) So practical a statesman as Governor Smith of New York has recently urged the adoption of a treatment-board device as a fundamental reform of existing practice. See New York *Times*, Dec. 8, 1927 (address before New York Crime Commission); *ibid.*, Jan. 5, 1928 (Annual Message).

In the September, 1928, issue of *The Panel*, the monthly organ of the Association of Grand Jurors of New York County, pages 7–8, a report is made to the chairman of the New York State Crime Commission, Senator Baumes, on Governor Smith's suggestion for incorporating a sentencing board into the criminal procedure of New York. A non-judicial sentencing board is therein opposed as "unwise"; instead, the report recommends a "court of resentence" for each judicial district, composed of one county or general-sessions judge and two justices of the supreme court selected by the presiding justice of the appellate division of the district. Such resentencing tribunal is to sit on specially designated days of each month, "to consider such additional facts bearing on resentence as may have been discovered after the imposition of the original sentence", in cases "where the prison clearing house believes, from social and medical study and investigation, that a different disposition should have been made". We consider this scheme unwise for at least two reasons: (1) It is uneconomical. Why "resentence" to correct errors? Why not sentence correctly at the outset? (2) The scheme does not guarantee that the resentencing tribunal will much improve upon the original court, since judges without any special qualifications for the work, and carrying on this important function only a few days a month as a "side line", will do the resentencing.

treatment tribunal to carry out its functions more intelligently than do the present criminal courts, it is not only necessary that it be an independent, specially qualified body, but that it evolve methods for the observation of the individual delinquent's progress under the treatment originally ordered, so that, if necessary, such treatment may be modified, much as the physician modifies treatment, in the light of progress.[1] Probably periodic reports upon and review of cases as a routine procedure of the treatment board would have to be provided for.

The fourth proposition raises the greatest technical difficulties. Here one must look to the fertile field of administrative law for devices which with appropriate modification can be adapted to criminal procedure. Indeed it must already be evident that the problem in its essence is analogous to those of various types of administrative instrumentalities. At least that phase of criminal law and procedure which begins with the sentencing function has or should have some of the earmarks of what is commonly called "administrative law". First, it is "public law"; that is, it involves the relationship of the individual to the state, or the social interest in the general welfare (security), instead of private litigation. Secondly, it contains an element of "preventive justice", in that, for effectiveness, it requires continuity of effort with an aim to prevent recidivism. The present procedure discharges criminals from penal institutions automatically, without much regard to whether or not further crime might be prevented by their continued incarceration. As long as the end of criminal procedure was punishment for the sake of punishment or even for the sake of prevention and deterrence as ordinarily conceived, the notion of continuity of treatment did not enter the minds of legal scholars; and indeed few students of criminal law seem even to-day to be aware of the

[1] We do not by this mean to suggest that all criminals are "sick people"; but that the same common sense that dictates observation of the results of treatment of various types in medicine is necessary (perhaps even more so) in the case of peno-correctional treatment of the individual offender. In brief, we are in a realm where the trial-and-error method will have to be resorted to. What must at all events be avoided is the present practice of slapping a man into prison and then forgetting him until he is again brought into court.

vital significance of this point. The sentence disposed of the convict until the end of the precise term prescribed in advance by a legislature which fatuously measured the length of punishment to make it just enough to restore the imaginary "balance" of the disturbed "jural order". In the meantime the convict was forgotten until his next appearance in court; and even then his past misconduct was frequently unknown to the trial judge. Nobody concerned himself with the response of the prisoner to the dosage of punishment prescribed him by this judicial medicine man. Unfortunately the use of the past tense in this criticism is not precisely justified; many legislatures still prescribe the length of punishment in advance, and many trial judges still mechanically apply this treatment without ever going near the penal institutions to which they daily sentence criminals. A third evidence of the administrative-law essence of the problem is that criminal procedure, beginning with the stage of sentence, if it is to be at all effective, requires technical experts learned in matters outside of the ken of the law—psychiatrists, psychologists, social workers, penologists.

Finally, when once we recognize that punishment *qua* punishment does not bring about the desired result of protection of society, and that constructive individualized treatment of offenders against the law is more likely to achieve it, we are met with the basic problem in administrative law—the need and the methods of safeguarding individual rights against the possible arbitrary action of a technically skilled, yet "all too human", administrative board.

In the light of these evidences of the administrative essence of penal procedure, it is surprising that Continental criminologists, such as Ferri, have resorted to the clumsy device described above—legislative prescription of detailed rules of individualization—as a way out of the dilemma of free judicial discretion versus protection of individual liberty. The field of administrative law would have suggested the much more simple and effective device of a treatment board. Discussion of the scope of such a tribunal's jurisdiction, its manner of functioning, its relation to existing services (parole, probation, peno-correctional régimes), and, above all, the legal means for safeguarding individual rights against pos-

sible arbitrariness on the part of the treatment body is beyond the scope of this paper.[1] The idea raises many vexing problems of policy and law, and much thoroughgoing study will be required to sketch in the vital details.

To make the work of such a treatment body effective, a temporary detention institution or "clearing house", manned by able psychiatrists, psychologists, and social investigators, would have to form an integral part of the board's equipment.[2] Careful records of examinations and field investigations of each offender would have to be maintained. Above all, however, the actual work of peno-correctional treatment—probation, institutional régimes, parole—would have to be greatly improved, and new devices experimented with. The

[1] Without discussing possible means of "judicialization of the administrative act" of determination of appropriate treatment for the "individual delinquent", it may be said that in general the solution of this problem probably involves, first, the definition of broad legal categories of a social-psychiatric nature within which the treatment board will classify individual delinquents; secondly, the safeguarding of individual rights by permitting the defendant to have counsel and witnesses (of fact and opinion), and to examine psychiatric and social reports filed with the tribunal, while at the same time avoiding a technical, litigious procedure, hide-bound by strict rules of evidence; thirdly, provision for judicial review of the administrative action of the treatment tribunal when it is alleged to have acted "arbitrarily" or otherwise unlawfully. I am indebted to Professor Felix Frankfurter's course in administrative law for valuable clues as to the intricacies of this general problem and hints as to the direction which its solution will probably take.

Collin (*op. cit.*) rightly points out (page 189) that since, under Ferri's system of minute legislative prescriptions, judges will not be called upon to "interpret the will of the legislator", but to investigate the nature of the individual delinquent, the course of judicial decision ("*la jurisprudence*") "will have to adapt itself constantly to the evolution of scientific doctrines", presenting the dangerous alternative that either the course of decision will have to follow step by step the development of science, "which would give rise to the most conflicting and perhaps most erroneous decisions", or judges will have to continue to apply the ideas of the framers of the project, "at the risk of maintaining, in the courts of justice, a scientific system abandoned by the majority of scholars". The system proposed herein will avoid at least the latter difficulty; since the *content* of the social-psychiatric categories could change with the advance of science, which advance it is presumed would be reflected in the techniques of the experts attached to the treatment tribunals. The former difficulty could be minimized by providing for a specialized appellate tribunal which would tend to unify the findings of the different treatment boards of a state, and for frequent conferences of the officials and associated scientists of the boards, for exchange of ideas on policy and treatment.

[2] The training of this personnel is a *sine qua non* to the success of the entire project. Present training facilities and prejudices are not suitable.

possibilities of various types of the newer psychotherapy in the treatment of offenders, for example, have thus far been practically ignored by those who deal with the problems of penology. Nor have different schemes of inmate self-government been sufficiently experimented with.

The system briefly sketched above would not necessarily involve changes in the substantive law; but no doubt modifications would gradually be suggested on the basis of carefully accumulated, scientific experience with treatment. Modifications in substantive law have not infrequently followed in the wake of procedural changes. Perhaps, eventually, the basic mode of analysis of crimes into act and intent, which Dean Pound has pointed out to be faulty,[1] will be radically modified. One can conceive, for example, that the effective operation of the type of board described will have its influence on the "tests" of the irresponsibility of the insane; it might even render them superfluous. It would probably also have its effect on the reduction of the number and variety of "degrees" in the definition of homicide, robbery, rape, larceny, and so on. It might, further, influence the substantive law of attempts. The minute splitting up of offenses into degrees and the distinguishing of attempts from completed criminal acts, with the meticulous setting down of supposedly appropriate dosages of punishment, belong to an era when punishment based upon degrees of "vicious will" as reflected in types of crime was thought to be the only or best means of coping with antisocial behavior.

The system under consideration should logically have as a basic provision a wholly and truly indeterminate sentence.[2]

[1] "We know that the old analysis of act and intent can stand only as an artificial legal analysis and that the mental element in crime presents a series of difficult problems." Pound in *Criminal Justice in Cleveland.* Cleveland: The Cleveland Foundation, 1922. p. 586.

[2] One of the most important resolutions adopted by the Ninth International Prison Congress in 1925 was that "the indeterminate sentence is the necessary consequence of the individualization of punishment and one of the most efficacious means of social defense against crime". Proceedings of the Ninth International Penitentiary Congress, p. 366.

Joseph F. Scott, formerly superintendent of reformatories for New York, in discussing the origin of the first American indeterminate-sentence law in New York, says that Mr. Brockway's original draft of the bill in 1877 "embodied an indeterminate sentence without limitation, which was approved by the board

The present "indeterminate sentence" is indeterminate only within maximum-minimum limits or embraces variations of this principle. The so-called indeterminate sentence of Ferri is, as was indicated, even less satisfactory. But even if concessions will have to be made to public opinion in such matters as murder and rape (that is, even if, as to certain serious offenses, *minimum* limits of an indeterminate sentence will have to be retained), the system ought to work more effectively than the present order. Similarly, if concessions will have to be made to public opinion in regard to such crimes as larceny (that is, even if, as to certain less serious offenses, *maximum* limits of an indeterminate sentence will have to be retained) the machinery ought to operate more satisfactorily than the present régime. It should constitute a promising as well as interesting social experiment.

SUMMARY

The underlying principles of a rational penal code are:

1. Society should utilize every scientific instrumentality for self-protection against destructive elements in its midst, with as little interference with the free life of its members as is consistent with such an aim.

2. To put this principle into practice, scientific individualization of peno-correctional diagnosis and treatment is necessary.

3. Professor Ferri's scheme of judicial individualization on the basis of a detailed legislative schedule of "conditions of dangerousness" and "conditions of less dangerousness" and a penal calculus is unsatisfactory. Individualization should be effected by a scientifically qualified treatment

of managers and incorporated in their report to the legislature. But, previous to its introduction in the legislature, fearing that the bill in this form might not pass, the draft was altered, limiting the sentence to 'the maximum term provided by law for the crime for which the prisoner was convicted and sentenced'." This has been the model for all subsequent legislation on the subject. Superintendent Scott was of the conviction, in 1910, that "had the section containing the indeterminate-sentence clause as originally drafted been left in the bill, it would have become law, as drafted, and would have given to us the purely indeterminate sentence which we have not been able to obtain up to the present time". *American Reformatories for Male Adults,* by Joseph F. Scott, in C. R. Henderson's *Penal and Reformatory Institutions.* New York: Russell Sage Foundation, 1910. pp. 89, 94.

board, to begin to function after the individual offender has been found (or has pleaded) guilty in the existing criminal court. In addition to the original disposition of cases, the treatment tribunal should periodically review the progress of offenders under treatment, modifying the original "prescription" (sentence) if necessary. The board should utilize existing scientific facilities (psychiatry, psychology, social work) in individualization.

4. Provision is necessary for protecting individual rights against possible arbitrariness or other unlawful conduct of the treatment board.

5. Certain modifications in substantive law may be expected to result from this basic change in procedure, and these, together with a truly indeterminate-sentence provision and improvements in peno-correctional practice, would facilitate the work of the treatment body.

THE FREEING OF THE TEACHER *

RUTH G. HARDY

Chairman in Economics, Girls Commercial High School, Brooklyn

FROM what do we wish to free the teacher? What is the difference between the good teacher in the traditional school and in the free, progressive school?

Something of the difference may be symbolized by the expressions on the faces of the teachers at two meetings that I attended last year. At one were gathered the women who occupy administrative or semi-administrative posts in the public schools of New York, many of them fine women, many of them my friends; yet as they settled down for the speeches and their faces fell into repose, I looked about me and thought: "Where is my eye to rest for the next hour?" For all beauty of animation was gone, and I was surrounded with mouths pulled down at the corners or set in a straight line, tightened in the fierce struggle with intense work or with the "wicked" males who get all the promotions with so much less effort. At the second meeting, that of a progressive group, the faces at rest were less saddening, yet the room was full of faces so determined to look pleasant that effort shot through the harmony of thought like misspent electricity. The second group were consciously directing personality in the right direction, but they had not yet achieved the calm of true freedom, where one need not think of one's mouth or any other feature in the certainty that one's expression, like one's thought, is unhampered in following the emotion of the occasion. The new education must find or, better, train teachers who will live in the harmony of freedom, free from wasteful nervous effort, free from self-consciousness, free most of all from emotional conflict or the emotional starvation that feeds upon the children committed to their charge.

What are the qualities of the "good" teacher in the traditional school? So outstanding as to have become almost

* Based on a lecture given at the Fourth Biennial Conference of the New Education Fellowship at Locarno, August, 1927.

a hall mark in the business is a "respect for authority" so strong that it can only be called timidity. That teachers are the most timid of workers is the first lament of nearly every educational leader, whether he wants to establish a new school, make an administrative reform, or organize a professional group. Teachers not only fear the educational authorities set over them, but invent dangers of dismissal or of censure where none exist; they create sadistic superintendents by eagerly awaiting the blow. There are reasons enough for this condition. Psychologically, in the state systems, teachers are drawn from the "good", docile children who learned what they were told to learn, privately achieved the art of passing examinations (and it is a real art, quite different from the art of learning), and won scholarships or high standing in college or training school. The really active, rebellious child, the student with a taste for innovation, can scarcely win the necessary references in many places. Socially, teaching in the United States is not highly regarded, and the teacher seldom rises above the stigma of this inferiority. More respected in Europe, he yet comes most frequently from a social class to whom teaching means a rise in the world, and he cannot forget the humbleness of his origins. In the eastern United States, among the people I know best, where social classes are rapidly becoming fixed, teachers suffer from both the American and the European inferiorities. Is it any wonder that personalities either repressed or immature, or even both, fill the traditional school with imaginary fears? For years I have preached to my colleagues—without, to be sure, any effect—that the proper attitude toward educational authorities is "respectful insubordination"—perfect politeness joined to complete determination to continue to do what one believes to be right. I have seen it successfully practiced without the label by the most admirable of my associates, but alas! they have been few and at pains to cover the tracks of their bold behavior.

With the growth of scientific pedagogy, an outstanding quality of a "good" teacher has been an impersonal interest in either method or subject matter. The teacher who read the educational journals, who attended graduate courses, who worked on new devices or statistical studies of experiments

has been held up as the model. Or teachers have immersed themselves in research in a particular field and taken advanced degrees in history or language or mathematics while teaching these subjects at school, with great credit to themselves as hard workers who were keeping up with the whole duty of a teacher. However laudable these activities, they share the supreme fault of overlooking all individual differences in children, so that we are coming to say to-day that the traditional school teaches subjects, but not children. And the more we look into schools dominated by this "scientific interest", the worse places we find them for young people and the more schemes we have to invent to rescue these young people from the time-table and the crowd and their own neglected personalities.

A third quality which the traditional teacher has always possessed, as a right and a glory, is the power of authority, exercised as discipline. Having obeyed, he was "good" in proportion as he got himself obeyed, and he has been free to get that obedience by any means, fair or foul. In the United States we generally forbid corporal punishment—and practice it, particularly in less honored districts, in its worst forms of cuffing or slapping. But nowhere do I know of a state regulation forbidding terrorizing a child with threats, or overwhelming him with a magnetic personality, or winning blind docility through a transfer of affection. In fact, this last, peculiarly destructive to character development, is often looked upon as especially meritorious, yes, beautiful.

In all these qualities it would seem to me that our general systems of education, children of the nineteenth century, have reflected the tendency of the nineteenth century to recognize and respect only what could be formulated in words or measured in figures. The spirit of man, whether in the teacher or in the child to be taught, since it cannot be formulated, has not been honored. The new education has arisen from the needs of the spirit, calling for the restoration of what it has lost.

Leaders in the new schools, in selecting teachers, are looking for spiritual qualities which they can hardly name, for whose discovery they have no trustworthy means, and of whose cultivation they are more or less ignorant. I have

gone about asking as many of these heads as I could reach: "How do you select a new teacher?" Some frankly do not know, but follow those obscure evidences of personality which the interview discloses to those who have what is called "a hunch for it". One woman who heads an experiment for which I have great respect said frankly that she had followed her intuition and had selected last winter one who proved to be "the world's worst teacher". The wisest summary of what the heads of experimental schools are seeking was given me by a man who stands for all that is finest in education: "What I look for, preferable even to knowledge of the new-school systems or educational experience, is wealth of experiences and emotional stability." This gives me the keynote to the qualities that the new schools call "good" in a teacher. We need to analyze this proposition and to discover by what means we may possibly train future teachers in these two achievements.

First, the teacher needs a wealth of actual first-hand experiences in the world in which he lives and to which the new school aims to introduce the child by beautiful and natural stages. The good teacher will know people and machines, he will feel richly in the spheres of color and line and music and drama, in which he will not only know the best that is available, but will have tried in some degree to create things expressive of himself. The good teacher will know deeply his own social environment and, broadly, travel will have given him knowledge of others. Books will not have been depended upon to give him these things vicariously, though they may introduce one to much, but books of worth should also give a direct experience of ordered thought and of human emotion. The good teacher will not be dependent wholly upon language, but will be able to use his hands in some of the crafts which are at once an expression of personality and a means of leading others. Above all, the good teacher will have experienced love and will bring into the classroom neither starved nor repressed emotions to seek compensation at the expense of helpless children. This is the newest of the demands that we make upon the teacher, and it is not of the sort that is most easily achieved by docility. The place has been found for the active, adventurous soul who has hereto-

fore been thrown aside or crushed by too many of our trainers of teachers.

Closely connected with this achievement of experience is the sense of joy in one's work. Really good teachers have always had this in some degree, though authorities have seldom looked for it or consciously encouraged it. It is this joy and the beauty that it spontaneously creates that have separated most clearly the work of the new schools from those bound by tradition. Without this joy, work for which one is perfectly prepared by the will and the intellect becomes a burden, dulling all one's vision, dragging back all one's forward steps, wearying one into the wooden endurance of a task. Then any previous experience, however rich, goes for nothing; emotion once experienced cannot be stored up for refreshment when the emotion is gone; it may even, like water carried too long across the desert, "go bad" and do more mischief than no water at all. But joy in the work one is doing means that nothing is too much trouble, no hardships are too great; personal attacks, even when untruthful, become nothing; misunderstanding only one more interesting problem to be solved in the day's activities. In her marvelously beautiful life of her husband, called *The Road to the Temple,* Susan Glaspell quotes the heading of one of the circulars George Cram Cook wrote for the Provincetown Players: "Work done in the spirit of play has the only true seriousness." Some of our experimental schools have grown out of the desire to give our children the natural right to learn through playing; now we would consciously seek no less happiness for the teacher. And not for his sake alone, nor for that of the children alone, but for the enhancement of both of them, working together.

In writing on methods in the new education, much has been made of the necessity for self-effacement of the teacher. It is true that in the classroom the teacher must appear to be in the background for the sake of the child's development. But this does not mean any kind of inactivity or passivity in thought or feeling. There are teachers tired by the traditional schools who think this self-effacement is an opportunity to do less in a pleasanter atmosphere. It cannot be made too plain that the teacher who is setting the child's environment and stimulating his creative powers must work far harder

than the one who is dramatizing himself and his knowledge before a group of quite passive youngsters. These tired teachers are the ones who lose control of the groups entrusted to their charge and, in discouragement, fall into more or less obscure illnesses or return to "old-fashioned" dictatorial methods with renewed zest.

There are others, more dangerous because they have a social motive, who believe that self-effacement is a call to self-denial, to one of the insidiously tempting forms of vicarious sacrifice. Experience cannot teach them that unless there is growth, there is regression, and this way lies sterility. Thought denied becomes dullness, emotion denied centers unworthily, expression denied grows a crust of stolidity, save only when denial in one direction is practiced for the sake of a fuller, better-rounded growth. These unhappy teachers who seek denial, self-effacement, for its own sake become either routineers or suffer those "nervous breakdowns" which were once looked on as a common consequence of teaching in a "new" school. The self-effacement that the new schools are really seeking is the self-effacement of the scientist before his problem; the teacher is so interested in the children that while he is with them, he has no time to think of himself. And this interest is not an emotional outlet; what the children do or do not do is not the personal concern of the teacher to satisfy or grieve him, but his pedagogic concern as each form of behavior helps or hinders the growth of the child. This is not coldness; it is absence of emotional disturbance, because the teacher already lives a rich personal life and does not need to satisfy his emotional cravings in the classroom. As Jessie Taft describes this impersonal approach: "The chemist is not annoyed with a chemical for exploding in a certain situation; he merely seeks to understand it so that he may control it in the future."

The scientific interest of the new teacher is bound up with this unsentimental approach. He is not less scientific than the good teacher of the traditional school, but his center of interest is different; instead of an abstract pedagogy or an equally abstract "subject", he bends his research to the reactions of the individual child, and his powers of generalization to the problems of growth under observable conditions. To

those who are striving in the new schools to build the environment that will be best for the diverse developments of individual children, research into "laws of learning" or eye span in reading or a thousand other possible investigations is enormously important, but secondary. They are of primary interest to graduate students and research workers in universities; it is important that the teacher of children have ready means of access to the results of such studies. But the primary object of scientific interest to the teacher is the best available method of observing and understanding the individual child. Furthermore, the abstract studies will probably be far more fruitful when they are undertaken separately by mature students who have previously experienced the actual classroom situation.

Last in this long list of desirable qualities, I should again place authority—but not in the form of discipline as it has been understood. The authority of the true teacher has always been that of leadership, the authority that is created in the mind of the disciple from the love of his master. Whether understood in a religious sense, or in analytic terms as a transfer of emotions, or practiced intuitively without a name, as it has been by the finest teachers, this is the authority that leads a child to a social personality and to powers of expression of which the teacher himself may not have dreamed. The value of the new psychology lies in giving the teacher an understanding of the means by which this love may be awakened, particularly in the difficult or unhappy child, and, better yet, the power to recognize the time for weaning the child from this love into a broader social life; and lastly, training in methods of helping the child to achieve his adult independence.

But how shall we secure teachers with all these qualities? Can we train the usual young applicant for such a rich life and such insights as the new education demands? Can these qualities be tested by any better means than the intuition of each head of a school? And most important of all, can we retrain teachers now in service, or keep up enthusiasm and emotional poise through the long years of service?

The new psychology prompts one to answer *Yes*. The exact means I do not know, and it will take the continued work of

many who are wiser than I to explore the possibilities, but I shall try to suggest a beginning. Several of the experimental schools now take a few student assistants and direct their training along the lines that I believe will serve our work best, but they are not able to fill their own vacancies from the small number so trained. For the great state systems, schools for training will always remain necessary; not only are large numbers called for, but training within the elementary schools on any but the smallest scale will suffer from all the evils of the old pupil-teacher system, in which the student was far too frequently sacrificed to the needs of administrative routine, or neglected by busy school heads whose interest in teacher training was merely nominal.

As I try to envisage the training schools of the new education, I see as a first essential an open door to rich experience of life. A school cannot take the place of the experiences that are brought by love, by happy social contacts, by hearing great music, by visiting the splendid places of the world, but it can prepare for meeting these experiences richly, with opened eyes and unhampered feeling. The ideal training school will not only give the best possible opportunity for experience, real and vicarious, but will aim to give to these studies that happy feeling tone which lifts studies out of the category of mere duties or intellectual exercises into a functional place in the student's life. It was my pleasure, in visiting English schools three years ago, to be recommended to Furzedown, a training college in London, which as nearly fills this condition as any school I have seen. I do not know the educational philosophy of the principal, Miss Lloyd-Evans, for in the day I spent there we talked of "practical" things, but I know she has created there a joyous, adventurous spirit, and that the students have an opportunity at many-sided development, not only in varied studies, or even in the well-directed observations, but in skill with their hands, in games, in dramatic presentation that combined all their skills with their own initiative, until I had only two questions to ask: "How can these young women get all this done in twenty-four hours a day?" and: "How can young women, trained in this brave, gay spirit, fit into the traditional elementary school?" In reply to my first question I was told, truly, that

joy in the work made large accomplishment possible, and individuals were carefully advised against overdoing. To the second, Miss Lloyd-Evans laughingly replied: "Oh, half my time is spent defending my girls against old-fogy head mistresses." One suspected, however, that these girls were free enough from hampering timidities to defend themselves in the use of new methods.

The training that will help to produce the emotional stability which the teacher needs must include bodily skills as well as intellectual and emotional experience. It is a very different thing from any amount of reading on the history of art or of industry to design and weave on the hand loom an actual article for use. The normal outlet for a human emotion is an activity pursued with the confidence of skill. Such an outlet, which I should commend above the customary games (with their elements of competition and of rules set beforehand), is the practice of rhythmic dancing, rich in opportunities for beauty and initiative, with no less bodily control or use of energy. The body needs development for honor as much as for health in the completed individual.

Intellectual studies can, I believe, be best grouped, first, about the observation of actual children, extending into reading in what modern psychology knows of human behavior, rather than into detailed methodology; second, about projects for research rather than about any particular prescribed bulk of knowledge. For it is the whole child who comes into the learning situation; his importance far surpasses the particular subject matter or researches into its formal presentation. One really trained in research is master of a method that he can apply at will as the situation demands that he utilize, for example, short cuts to reading, or that he immerse himself in a particular new subject—say, the life of the vikings, when the needs or interests of the children in his charge call for that fine primitive outlet.

The head of such a training school needs far more to be a "ped-analyst" (to use Dr. Pfister's term) than a student of educational theory or an organizer of curricula and field work. His primary duty is the development of personality in the students who will soon be teachers. He needs to watch them, to understand their difficulties, to help them to under-

stand themselves and to curtail or fill out, as the need may arise, the particular powers or tendencies each may have. To organize a school and neglect the differing needs of the students, thinking of them as so many groups or classes, is to fail in the very purpose of *training*.

Lastly, a good training school will furnish opportunities for both self-effacement and self-assertion—self-effacement in the active sense in which the real teacher observes children, attempts to analyze what he observes and to plan for appropriate activity; self-assertion, in the freedom that comes from one's own activity toward a definite end, best accomplished, in groups, by dramatic presentation, as individuals, in handling actual schoolroom situations. In this setting "practice teaching" takes on a new significance.

If we can train teachers along these lines, how shall we test their fitness for the independent practice of their art? We cannot trust records at school; at its best, a school cannot supply situations of real independence. Still less can we trust opinion, "hunches", as most of the heads of the new schools have had to do. I believe that some of our research institutions are working in the right direction in developing standard-scored tests of "personality" and other tests of judgment in concrete situations. The first sort are still distressingly crude. The best example that I know of the latter sort is the Knight-Franzen test for teaching, worked out at Teachers College in Columbia University. To such tests of many items, impersonally scored to norms, I should add some such test of ability to think and to arrange one's knowledge as is required in the preparation of an original paper or, better—as I understand is done in examination for entrance to some of the higher institutions of France—in oral discussion, for a half hour or more, of a pertinent subject. This supplies the necessary opportunity for original thought, for human variousness, to get due recognition. It should properly be an actual test of independence of thought; in the new schools an adventurous spirit is more valuable than conformity. A school head who has not himself sufficient emotional stability to value differences from himself might better cease to be a supporter of the new education.

The problem of maintaining the high qualities demanded

by the new education is, first of all, the problem of remaining constantly alive, so that the flow of rich experiences never ceases and the teacher's mind remains plastic. Then the continuous impacts which the world is bound to give produce creative reactions; they are not overwhelming, as they are to weak spirits, nor are they repulsed by a defensive indifference. Graham Wallas has pointed out that most people have an impulse to teach which carries them along, if they become teachers, to about the age of forty; then the abler ones are drafted off from the classroom to administrative posts and those who remain frequently cease to live. In the new education we would see greater honor given to the able who remain in the classroom than to those who sit in administrative chairs, for it is the former who affect the children directly. And I believe that continued plasticity, long after forty, may be maintained in the classroom by honor for the teacher, by such leaves for outer experience as are now becoming customary, but, above all, by the teacher's own scientific interest in living and working with children.

Second, the problem of remaining a good teacher for years is the problem of self-control—that is, the problem of understanding oneself, one's pupils, one's fellow workers, one's world, so that action grows ever more appropriate to intention. There is no end that has ever been found to the knowledge of human nature—why each individual acts as he does, how he may be influenced to act, to what his acts may lead. It is the most fathomless of the subjects for human interest. This interest, not as a mere study, but as a living sphere of activity, is always the center of the teacher's field; it is this that properly makes of teaching the most adventurous and creative of all the skills.

Again, the problem of remaining a good teacher is the problem of maintaining the tension of work without the wastes of strain or excitement in those many hours when we cannot be creative. In America, where life goes on at high speed, we frequently say that some one is "too tense" to do good work; what we really mean is that muscular and spiritual force is being wasted on what is not work. When the time for work comes, we need the tension, all we can get of it. But if we understand ourselves, we know when work is ended and

when it should end, and relaxation comes of itself without another exertion to waste our force. Teachers too often lengthen the moments of tension into hours, even years; then wonder at the unrhythmic level of their lives. That the classroom does not call for tension is the real meaning of self-effacement. The teacher watches, suggests, notes what occurs, records the different reactions, guesses whether they are tending to good in this child or to lower ends in another subjected to the same conditions; this is not a work of strain or excitement. The real tension comes when, alone, after the children are gone, he examines these notes and the possibilities before him for modifying bad situations or encouraging good ones, the material available to meet the emerging interests of each soul within his care. Then he needs the highest tension in all his powers, for it is his great moment when he creates. The beauty of creation is his when he is able to set an environment for growth out of his contemplative study.

Last of all, the good teacher, like all wise men, knows that neither personality nor freedom are things achieved, but a continuous becoming. This becoming is from day to day—yes, from moment to moment, toward better or toward less worthy action. By knowledge, by understanding, by watchfulness, we can lead this becoming where we will, but we cannot with safety neglect it, even if we have no ends to achieve. In so far as we have ends to attain that meet social needs, both the good teacher and the pupils whom he leads will grow, without the sacrifice of any side of life, in happy, conscious activity.

EMOTIONAL HANDICAPS OF THE PROFESSIONAL WOMAN

ELEANORA B. SAUNDERS, PH.D., M.D.
The Sheppard and Enoch Pratt Hospital, Towson, Maryland

I RECALL a nurse, estimable, worthy, and efficient, who had, however, only one viewpoint—her own. She erected a barrier against coöperation with associates, was strict in discipline, "absolute" in her ideas of right and wrong, rigorous in regard to the social relations of the nurses—in fact, they called her "cut steel". We may speak of such a woman as inflexible or repressed—praiseworthy, but difficult.

Here is another case, also that of a professional woman, who developed a love affair that ended in pregnancy, with isolation, social estrangement, feelings of being cut off, and a yearning for some one who understood. A flight to work was the only thing that made life tolerable. The isolation, the silence and seclusiveness, continued over a period of sixteen years. Then when her son, having been taunted in the street about his parentage, demanded full enlightenment, the long silence was broken with an acute attack of what psychiatrists call "confusion". At this time she spoke rather more freely, but then drifted back into the silence that had endured for years. She recovered from the psychosis, during which she had not been communicative and in which she did not develop full insight or understanding, only to lapse again, but this time into a less rigid condition than before.

The lives of these two women present a striking enough contrast, yet one may say with some truth that each in her way was attempting to solve the same life problem.

Lack of ease in personal adjustment, self-dissatisfaction in women, accompanied by a determination to forget, to make the best of things, may be an evidence of determined self-control. The reactions in such cases may be rigid; they may seem to be lacking in understanding and sympathy, with an appearance of harsh indifference that represents a struggle

within themselves. Because of their own emotional stress, they may seem intolerant of those who present to their official attention a problem similar in nature to that which brings up painful associations in their personal lives.

Inability to live out emotional reactions through adequate channels makes for efforts to forget and attempts to push the disagreeable thoughts from attention. Women in this situation often seek a means of flight, so to speak, from themselves. Work for them may be a form of protection. Many women disappointed in love or marriage take up nursing or go into a sisterhood. This flight to work serves as a substitute for an outlet at the emotional level, and gradually there is a lessening of the capacity to feel keenly. In some cases there develops an unwillingness to take part in any activity that may bring about a painful emotional stirring. A prolonged effort to forget may develop into a determination not to "feel" anything. A narrowing of interest in pleasurable activities, a guarding against the feeling of pain, lead to a difficult personality, with an appearance of lack of sympathy and failure of perspective. So often we see a rigid, austere forewoman, or charge nurse, who demands that a cut-and-dried plan be followed in her own life and in the private lives of all those under her.

Such experiences lead one to believe that greater efficiency in work and in personal ease, added security in mental poise, and a lessened liability to mental illness may be brought about through an adequate expression of the emotions and by the removal of the handicaps that result from pent-up emotions.

Under the heading "emotional handicaps of the professional woman", I wish to discuss some of the evidences of a lack of adequate emotional outlet in women of this class. These manifestations may assume the symptom expression either of physical disabilities or of mental maladjustments. A search into the cause, however, will disclose an emotional factor at work—a body-mind interrelationship in cause and in effect.

If we conceive of the psychobiological development of a woman as a growth of mental and physical capacities, we will recognize that there must be a unification of functions

in the mental and physical realms. The components must be developed harmoniously if there is to be ease of activity. We sometimes think of these components as personality—that is, the equipment with which one is born plus that which is accumulated as the result of experience. These personality traits may be considered as instinctive and acquired, but there must be an harmonious relationship among them to make for that ease of adjustment which we call health. All the components of personality should grow and develop as a whole, if there is to be the maximum efficiency.

From studies of mental life we have learned that the integration of the parts makes for ease of adjustment to the surroundings, the organism, in a kind of two-way activity, acting upon, and in turn being acted upon by, the environment. Experience is a series of reactions and adjustments to the environment, and modifications of it, which mean, in our more or less complex social and economic existence, the necessity for accommodating both the individual to his environment and his environment to him. In this process of adjustment, there is a give and take that leaves impressions of greater or less intensity upon the individual. White says, "Adjustment to the world of reality is by no means a passive molding by external forces. The individual is reaching out and trying to mold the world to suit himself. In this effort he develops attitudes which, like habit, grow and in their development cause the pushing back of expressions of emotion."

In the attempt at adjustment through a period of years, many alterations of personality may be effected; certain traits may be stunted, others developed. We speak of a calm, impersonal, professional attitude. This is evidence of an effort to mold the personality to fit the environment. The events of to-day may be the means of recalling hidden or forgotten experiences, even those of early childhood, which are surrounded by a painful emotional tone. Unusual reactions to minor or insignificant events may represent far more than the feeling about the particular situation in question.

Our reactions to casual events, our first impressions of people, our associations of one person with another because of some similarity, may link the present with our past.

Pleasant or painful emotions may be brought to the surface by some trivial or apparently irrelevant occurrence. The pushing back, the forgetting, the burying of painful emotions or events, may make for inflexible attitudes, the result of the instinctive urge or desire, we may say, to spare ourselves pain and to fit into the requirements of the group. When a woman fails to meet these requirements, there are feelings of inferiority on her part. When she feels the lack of approval of the community, the loss of esteem of the group, she is apt to lose her self-esteem. To be comfortable, she must grow and in a great measure appear as do others. This may be a so-called conventional requirement, but there is an instinctive desire to be like other women. The history of the development of the human race is full of evidence of this instinctive desire to meet the demands of the group. Fraser, in *The Golden Bough,* gives numerous instances of it among primitive people. Trotter, in *The Herd Instinct,* and Flügel, in his *Psychoanalytic Study of the Family,* illustrate this urge among the people of a more cultivated level.

Success is measured by ability to fit with ease into the requirements of the community. There may be individuals in whom this conformity to the group is accomplished with great discomfort. There are others who are unable to accommodate themselves to social requirements, and efforts to force such accommodation make for an outcropping of the opposite tendencies. The cause of the nonconformity may be of long standing. Many of woman's instinctive cravings or desires are unsocial. While her ethical self longs to live on an acceptable plane, her instincts may demand satisfaction at another level. The inability to harmonize the ethical and instinctive desires makes for a struggle that is often relentless. This struggle may actually be a sort of groping in the direction of right, even in cases where the behavior on the surface appears antisocial.

The delinquent, the psychotic, the psychoneurotic, the criminal all represent inability to fit in with the group. These expressions of conflict within the self or with the so-called conventions meet with sympathy or censure according to our conception of the degree of responsibility we place upon them. The cause or motive of the inability to fit in with the con-

ventions is too often neglected or misunderstood by others who have been more successful in life. Disability may even result from attempts to appear like those others who have met with greater success. A failure may actually represent a great effort to find the solution of a struggle. Many women have found social conventions out of harmony with their instinctive needs. We must remember that while ethical or social standards vary in different communities, the basal or primary instincts remain constant.

In our modern civilization, a new problem has been presented to women in the breaking down of old economic and social barriers and the opening up of new opportunities. The traditional limitation of activity, the necessity for protection and support, are being challenged on all sides. Belief in woman's capacity has varied from the point of view that relegates her to the field of household cares with adequate protection to that which places her on an equal footing with man on a high plane of economic efficiency. But her biological cravings remain constant.

We think of a personality as flexible or as rigid according to the extent of its capacity for sympathetic identification with, or ability to see, another's point of view. There are those who remain pliable and understanding, and there are others who have apparently forgotten youth and its longings and who appear as automatic, though efficient human machines; they have apparently lost all human qualities. The development of some one capacity has been accomplished, but at the expense of a dwarfing of many of the personality components. Intellectual and official acumen have been gained at the cost of emotional ease. The demands made by civilization upon women's capacity for self-control and self-denial are often so great that feelings are pent up without an adequate outlet. In primitive people and in children there is a freer expression, with far less of the conventional suppression. This damming up of emotions makes at times of special stress for irritability and ease of anger reactions. We often hear these women say, "Everything went wrong. It was just an accumulation of things." Out of this attitude there frequently arise feelings of inability to cope with situations. A fear of unsuccessful attempts at competition, secret misgiv-

ings, fears, and a sensitiveness to comparison bring about a feeling of lack of fair play.

Secret longings, rigorously repressed, often reappear in the form of delusions of persecution and hallucinations of sight and hearing projected into the outer world and thereby, as it were, disowned. A well-rounded development of personality, with adequate emotional expression for the inner cravings and desires, makes for ease of adjustment and understanding of the longings of others. The rigid personality is usually under stress of emotion which is kept hidden and cannot afford to recognize the right of this emotion to satisfaction in others. The painful content of thought and feeling make a kind of forgetting necessary. Ideas fraught with painful emotion must be avoided, and as a result are not seen in the self or in others. These women are not able to establish a proper feeling tone about things and events that bear upon their pent-up emotion. Biased opinions of things of which they are ignorant preclude clear thinking. As a result, many situations bring up facts which they are unable to review without great personal stress. Opinions and reports or impersonal official questions are often colored by an over-reaction to the situation, whose intensity depends on purely personal experiences.

Disappointments, failures to acquire longed-for love objects, marriage, ambition, or anything really wanted may bring about an exaggerated tendency to anger or irritability. Those who are very tense and pent-up may show an anger reaction or testy attitude with the slightest provocation. Often associations of thought without any disturbing event may bring about a noticeable change of mood. We hear them say, "I got to thinking." Pondering, wishing, ruminating over the past, make for moods that have little tolerance for the irritations of the hour. Sensitiveness to offense, feelings of discrimination, bring out reactions of a longing for desired attentions and satisfactions. I recall a nurse who is now forced by age and physical infirmity to accept a menial position, when formerly she was in one where she commanded a greater degree of prestige. At the present time she is irascible, offers objections to every suggestion, and is very critical. She scolds, argues, and finds an outlet for an otherwise unexpressed emotion in resentment toward her superior nurse. Necessity for

accommodation to unpleasant situations creates a degree of tension that finds easy expression in scolding.

I am sure many of you have come in contact with women of highly organized make-up, who, when fully occupied and interested in philanthropy, are cheerful, but let there be a lull in diversion and they become introspective, with an increased interest in themselves. The leisurely classes of American women bear witness to this fact, and the war record of many invalid women shows the healing property of a vital interest. Widowhood, loss of money, or the like, may reduce a luxurious invalid to the stern necessity of earning a livelihood and coincidentally a return to health.

In women of this type ideas surrounded by painful feelings may be hidden and crop out in another guise or form as invalidism. There may be a conversion of the mental conflict into physical symptoms. In many women the stress of competition is a burden. The fear of being supplanted grows with the feeling that more youthful associates, with greater capacity, may take their places. For them illness is an honorable flight.

A stenographer of fifty in a very progressive manufacturing establishment felt herself in many respects incompetent to keep up with those about her who had a much greater earning capacity and superior training. With each added evidence of her inability to compare favorably, there were attacks of invalidism. The death of her father, the illness of her mother, were added burdens. She depended upon an indulgent chief until the company changed ownership; then there were evidences of greater inferiority. With this she began to develop a condition resembling writer's cramp. She was at last admitted to the hospital, where for a period of six months she worried over her lack of income, her gloomy future, her loss of prestige. Every added evidence of stress brought out new manifestations of bodily disease. In some of these so-called invalids there is a tyrannical attitude. The following is a case in point:

A. K., a nurse, is a member of a neurotic family, the women being zealous Catholics, the men somewhat more desultory. The patient developed a feeling of responsibility for the laxness of her brothers. After a disappointment in a love affair,

she attempted nursing, but did not find it satisfactory. With the development of a rather casual physical disease, she learned that comfort may be derived from the attentions given an invalid. This idea became somewhat fixed, and she resigned herself to ease and luxury and became definitely tyrannical, selfish, and antagonistic. There were many complaints of indigestion, gall-bladder disease, nervousness, and an inability to work.

For a period of twenty-five years, she has made many demands on an indulgent family and has shown a childish satisfaction in their attentions. She makes unlimited demands in regard to food and medicine. Much of the time she is in the home of relatives, but at infrequent intervals she is admitted to hospitals, where she is mandatory, critical, and petulant. Her complaints are of a somatic nature and refer to "nervousness and to terror dreams of snakes, of water, and of falling".

Interest and enthusiasm make drudgery a pleasant duty, but an unloved occupation brings daily stress and exhaustion of spontaneity and buoyancy of living. The necessity of daily application to duty in an occupation that is distasteful or that is not satisfactory is another source of discontent. After a period of successful work, one patient made an unsatisfactory marriage. There was a daughter and subsequent desertion. Being forced to earn a livelihood, she found work as a secretary. Here she was for a time happy, but, on a change of directors, she felt pushed aside, considered her work of little importance and of a monotonous type. Financial straits forced her to live with her elderly parents. Her father, an invalid with tuberculosis, her neurotic mother, and her young daughter made demands on her time when away from work. Her evenings in the home after the daily routine was completed offered no recreation or personal satisfaction. She developed a depressive reaction with many distressing notions of the death of her parents and of her daughter, associated with a feeling that she had killed them or that she had in some way permitted their death by violence. Again, she hallucinated their voices as if in pain near her. After a prolonged illness, she made a more successful adjustment of her life, with increased attention to her recreations and to securing

work of a more satisfactory nature under more comfortable conditions.

Here is another case of a resort to invalidism when all other outlets had failed, this time on the part of a non-professional woman who had tried and failed in the rôle of wife and mother:

D. G., Sicilian, staunch Catholic, married the man of her family's choice, but continued to love another—of her own choice. There were five children, but with the lapse of time the husband became interested in his work and was indifferent to the patient, who longed for attention. When she realized that her husband was finding consolation in the companionship of another woman, she began to be more childish and whimsical in her demands and to create situations in which she could force the attention of her husband and of her children. She became intolerable in the home on account of the demands on their time and her petulant arrogance made it impossible to placate her whims. Her daughter reports an incident in which eleven eggs were prepared for breakfast. Each attempt was met with a criticism of its being too salt, too cold, too well done, and so on. The day was filled with such experiences. There were many complaints of somatic discomfort and later ideas of "queer" bodily sensations: "I can't get well", "My face is drawn", "I have a jumping feeling in my stomach." There were many requests for examination which were used as a means of attracting attention. Along with the tyrannical demands there were many threats of suicide when foiled.

There are those who pass their early years in an environment of invalidism and who learn by imitation to react with sickness in the face of difficult situations. There is a patient now in the hospital whose father had tuberculosis, whose mother was neurotic, and whose grandmother was an invalid as the result of a hip injury. This patient learned the habit of somatic interests. With an unsuccessful marriage after a professional career of about two years, she began to express many hypochrondriacal tendencies upon encountering emotional stress or any difficult situation.

I recall a young woman, a librarian, whose father, a confirmed invalid with imaginary heart disease, ruled his children with the cry, "Now, you will kill me!" The patient

apparently compensated for this attitude with an unusual interest in athletics up to the time of a disappointment in her lover, who deserted her. She then passed through a period of intense depression and drifted over from lamentations upon her loss to ponderings about her bodily functions. She had an unusual capacity for describing the sensations associated with physiological processes.

Success and confidence give way to doubt and misgivings when there begins to be a realization of loss of prestige, capacity, or position. Conscientious types of women develop an emotional stress, which, if not disposed of at the conscious level, frequently takes on certain physical manifestations. The invalid, unloved wife who demands attention and creates situations that command it is a case in point. A very efficient professional nurse married a physician, less powerful in his make-up than herself. After a short time she learned that his interest had drifted to other women. She became depressed, had many feelings of shame, and felt herself looked down upon by the community. She was unable to face the fact that she had lost her husband. She became tense, and somewhat suspicious and irritable. In her illness there was a dilapidation of habits and a recrudescence of erotic interests.

Often women of more mature years realize that competition with youth and its effulgence of energy results in a comparison unfavorable for them. Humiliation because of their waning power makes them unable to accept the fact that they are losing. They cannot realize that it is their failing capacity, but project the responsibility to another. They develop the feeling that they are being kept back and that there are those who "work against" them. The aggressive types, when they begin to feel secret longings and misgivings, may become more and more uncomfortable. They begin to feel that the environment or some force outside of their own thinking is affecting them. They feel slighted and tend to become suspicious. They "know" that people are working to their discredit; then they may begin to hear accusing voices of friends at a distance. Sometimes these voices suggest women they know, sometimes it is an enemy. They blame external forces for the shortcomings within themselves, as a well-known psychiatrist has said. Many of these women develop secret attachments to some man

for whom they work. Often they feel he is indifferent when perhaps he does not know of their feelings. As a result, they are pained by his attitude toward them, and they begin to hate him. They think something comes from him to do them harm. They feel themselves against a stone wall and cannot realize that the trouble is in themselves and not in the other person. Then the "malign influences emanating" from persecution, danger, and so forth, necessitate the development in them of means for protection and defense.

C. L. was a professional woman of outstanding intellectual capacity, single, aged fifty-seven, a teacher and research worker. The patient's mother was epileptic, her father neurotic, and her favorite brother psychotic. In early life she felt herself an unwanted child. She developed a tremendous urge toward scientific investigation and research work and spent much time in Europe and America doing valuable work with tissue cells. Her interests were along intellectual lines without emotional outlet. She began to feel that her associates were trying to steal the results of her work. Then she thought these men were attempting to circulate stories of immorality on her part. She was convinced that her young woman assistant, who was somewhat modern in social habits, would bring discredit upon her. She then began to believe that she was being watched and followed. There were definite ideas of assault, and she resorted to many means of protection. When placed in a hospital, she was certain that men tried to get into her room at night. Then there were delusions of grandeur, in which she thought that she was to be held responsible for a World War. She also thought that her death would in some way avert or postpone such a condition indefinitely. After five or six years she committed suicide, having said on many occasions that she would do so for the purpose of saving the world.

E. W., aged fifty-eight, single, was an artist. She was the second of three children in a Quaker family. The father was psychotic. The patient had a tremendous urge toward full satisfaction of her emotional life, but was restricted by her parents, who were satisfied with much less. After a disappointment that resulted in a broken engagement, the patient at nineteen developed an attack similar to the father's illness.

The successful marriage of her sister brought about feelings of inferiority on the part of the patient. She talked of "others who deprive me of what is my right. They keep me from it. They interfere." In her periods of excitement she talked of loneliness and of wanting love. Later she began to develop more definite tendencies to projection. She thought strange men and women were trying to assault her and that they put "words in my mouth and thoughts in my brain".

The cases quoted so far all illustrate the way in which the natural longings for love and power that have failed to find adequate outlets in real life may be deflected into other channels in the attempt to find relief. Thus a thought or an activity less painful than the true cause of the distress may be substituted for it.

I recall an only child, devoted to her father, with some hostility to the mother, who was always timid and at five developed a fear of being "penned in closed spaces". Later there was a fear of animals, then of injury by sharp objects which might come in contact with exposed parts of her body. During an illness in which she was very emotional, there were erotic ideas about her father, later associated with religion and God. There were feelings of unworthiness, dissatisfaction, and great depression.

Another patient is the daughter of a rigid, devout widow. At puberty her mother talked much to her of the uncleanness of sex, of the dangers of physical exposure during the menstrual period, of conventional restrictions, and of means of protection against "immoral people". The patient developed a tendency to masturbation, and when she reached the age of puberty there were feelings of inferiority, of being looked at, and of being unclean. She developed the habit of hand washing which was necessary "to keep me clean". There was first a fear of contamination from the physical standpoint, then the uneasiness shifted into the spiritual realm with the necessity for greater religious fervor and confession. Attendance at church was discontinued on account of the danger of contamination, and the patient was almost completely incapacitated. While employed in a clerical position, she became so much preoccupied with the hand washings that it was impos-

sible for her to do acceptable work. She became increasingly more submissive, prudish, preoccupied, and shy.

Ideas of an obsessive nature may represent a kind of compulsion, in which there is an additional feeling of being forced to do or think certain things. There seems to be an accumulation of tension, with calm after the impulse has been carried out. This has been frequently given as the reason for tendencies to burn or steal, and other activities of an unsocial nature, to which the patients feel themselves driven. A similar impulse may be seen in persons who in walking along the street must not touch certain objects or who must carry out a given activity a certain number of times. Cases illustrating this obsessive tendency could be multiplied indefinitely. The following are typical: A patient who was the ward of a philanthropic society began at five to show evidence of a childish sex curiosity. At eight there were evidences of sex interest. At nine or ten there were attempted sex relations with boys. At nineteen there was a fancied or real assault followed by emotional outbursts of a hysterical nature. The patient was tense, had feelings of shame, and was very unhappy on account of a tendency to sex ruminations. There was almost a compulsory tendency to masturbation, with active daydreams and night terrors associated with thoughts of normal and perverse expressions of her sex life.

In a period of great stress, a conscientious woman left in charge of a business establishment developed a fear that certain duties had been left undone. She had no peace until she had gone around to inspect each point to be sure everything had been closed up for the night.

Another patient, who was very much disappointed in her husband, refused to think of his inconstancy and alcoholism, but began to worry about whether or not the glass of water which she demanded frequently was exactly full. She became agitated and was often in a kind of frenzy, repeating to herself, "Is it full? Will it hold another drop?" It required much urging, and sometimes coercion, on the part of her children to get her to drink the glass of water. Then she was momentarily satisfied, but the same process had to be repeated many times during the day with other glasses of water.

A student, sixteen years of age, with a very strict upbring-

ing, began the habit of taking three steps backward, then three to the side. This was in time followed by a tendency to rhyming and other repetitions of similar nature.

A very competent craftswoman, after a disappointment, developed a ritual about the articles in her room. Everything had to be placed in a certain position a certain number of times. Shoes were placed under the bed, removed, and replaced four times, before she could leave them. Another patient was forced to arrange everything in very orderly fashion. These ceremonies and evidences of great indecision may often refer to early sex experiences to which may be added a sense of guilt or apprehensiveness. An elderly patient admitted that her indecision in regard to dressing, shopping, or the daily routine dated back to a childish preoccupation with masturbation, and frequently the tendency, "Shall I? Shall I not?" referred to the early childhood habit rather than to the daily activities.

Slander, anonymous-letter writing, risqué jokes, and blackmail are often manifestations of pent-up emotions which find an expression in a childish manner. These may represent early experiences with sex subjects. There may have been sex secrets or frank sex acts in childhood with which there is associated in later life self-censure, shame, or diffidence. The letter writing and slander may represent expressions of sex emotion in which there is an element suggestive of the habits of primitive people with a desire for exhibitionism. Frequently these manifestations are based on sex curiosity. The opposite condition, prudishness, represents a protection against the same desire.

A woman, thirty-seven, single, was brought up in a very quiet home with religious surroundings. She had a tremendous emotional drive, but was pent up in her love life. She found expression in paintings too poor to afford real satisfaction. She accepted a position as a secretary, but could not adapt herself to the surroundings. While associated with a minister in a philanthropic movement, she developed an attachment to him and began to show evidences of jealousy of another secretary. She began writing anonymous letters and sending telephone calls. She was somewhat crafty in arranging these calls so that there could be no means of iden-

tification. Other evidences of very erratic behavior necessitated her being placed in a hospital for mental diseases. Here she excused her behavior by saying that it resulted from jealousy and a determination to get even. We read almost daily in serious context, or in the comic strip, references to such cases. A review of our domestic-relations courts will afford many instances of similar nature.

Flight from intolerable situations may be accomplished through the use of drugs of various kinds. In this habit there is a tendency to rationalization. One person "drinks to avoid company, another to make him more at ease with company". Many of these cases are simply mental illnesses. Artists not infrequently tend to indulge in alcoholic drinks, and many women of the leisure class resort to the same means of relief. Nurses and doctors have a tendency to drift into the habit of hypodermic medications of various alkaloids, such as cocaine, morphine, and hyoscine.

Sometimes the craving for these stimulants comes on only at intervals when the underlying tensions become intolerable. An artist, unhappy in her marriage, reported that from time to time she was driven to the necessity of taking, over a period of weeks, absinthe and whisky to the extent that she was unable to realize the conditions about her. She went into her apartment under the care of her maid and protected herself from painful thoughts. Then, after a period of time, she appeared more at ease, and was able to go on with her work for several months.

Another patient, very unhappily married to a periodical drinker, developed also the habit of alcohol and drugs. Separation from her husband and removal into surroundings where it was easier for her to obtain an adequate emotional outlet made it possible for her to attain satisfaction in the occupation of her choice.

Another patient who was very unhappy and somewhat hysterical in her emotional outbursts was given hyoscine. She gradually became more and more dependent, and at last developed a hyoscine habit. She said that after the administration of one of these tablets, she had a period of almost complete unconsciousness for three or four hours, after which

she was able to go along with a fair degree of ease for several weeks.

In the ordinary day of the average person, much time is given to the daily occupation, but a good deal of this work is actually done in a kind of automatic fashion. Typists and other kinds of artisans have developed a habit of relegating their work to the lower centers, and often spend much of their time during the day in fancies and daydreams while they carry on the daily routine.

The psychology of choice of occupation, the mental effects of the stimulating qualities of certain types of occupation, and the blunting effects of other monotonous duties have attracted the attention of the applied psychologists of the day. With the more monotonous types of work, there is a disposition to drift into daydreams or the building of air castles. These fancies are frequently upon a childish basis, and are often out of keeping with adult thinking in the world of reality. Conflict between these daydreams and the actual reality may make for unexplained irritability. Stekel, in his *Polyphony of Thinking,* has used the comparison of an orchestra in which there is not complete harmony of the parts.

The success with which women meet their personal problems is a measure of their success in the world at large. Their difficulties with associates are frequently a reflection of difficulties within themselves. The discovery that their problems are not confined to themselves, but that nearly everybody has to fight the same battle more or less is often a means of gaining more understanding and from this more sympathy for others. Draining off emotional tensions little by little in sharing with others their troubles in sympathetic understanding has proven a help to many. Women often reach a solution of personal difficulties by resolving those of others. A vicarious or indirect approach may be more tolerable to them and may mean much less wounding of pride or loss of self-esteem.

With greater sympathy, there is less criticism of the motives and attitudes of others, and in this way they become more nearly adapted to the situation which may refer to themselves in some manner. This may mean the development of freedom from feelings of shame and inferiority, with resulting additional harmony within the self and with the daily life.

While much of our thinking is by a process of "feeling" rather than through the medium of words, a great deal may be brought to expression with some one who understands. In this way pain and bitterness are lost. To develop a talking basis of confidence and frankness is a great factor in the release of emotion. Much material that has previously been subjective becomes more objective, less a part of ourselves, and, therefore, less painful.

Creative work of a pleasurable nature, such as painting, music, writing, designing, and so forth, in place of indulgence in fancy or in daydreams, is a distinct source of satisfaction and should be developed in some form. The little inner personal pleasures that afford satisfaction should be cultivated just as is business efficiency.

THE SEX OF MENTALLY DEFICIENT INDIVIDUALS

OLGA BRIDGMAN, M.D.
Professor of Psychology and Pediatrics, University Hospital, University of California

THERE have been many studies of mental retardation and mental defect in relation to the sex of school children, and the results of these studies are in general agreement. It appears that wherever sufficiently large numbers of school children have been tested by so objective a method as the Binet scale, the results show that, on the whole, sex differences are so small that they may be disregarded. As to the relation between sex and intelligence within the feebleminded group, it is also generally agreed that there are slightly larger numbers of feebleminded boys than of girls. Tredgold, computing results from the reports of the Royal Commission on the Care and Control of the Feebleminded (1904), concludes as follows: "It is seen that, considered either in regard to each degree or collectively, there is a slight preponderance of the male sex, the relative proportion of males to females being practically as 6 to 5. . . . It is of interest to note that the ratio of males to females is highest of all in the group of feebleminded,[1] in which there are approximately 3 males to 2 females."[2] Tredgold's table follows:

Showing the Sex of Aments

			Feebleminded		
	Idiots	Imbeciles	Adults	Children	Totals
Males	303	959	3,244	2,179	6,685
Females	282	848	2,193	2,112	5,435

The figures in the above table were obtained without the use of intelligence tests; indeed, at the time that this survey

[1] In England, the term "feebleminded" is used to denote the highest of the three grades of mental defect, corresponding with the term "moron", which is in general use in this country.

[2] *Mental Deficiency*, by Alfred Frank Tredgold. 4th edition. New York: W. Wood and Company, 1922. pp. 18 and 19.

of Great Britain was in progress, the Binet scale was not yet in existence. The diagnosis of mental defect, in its various degrees, was made by groups of skilled observers, and the standards must, of course, have varied somewhat with the different individuals who made the observations, since entire agreement would scarcely have been possible without the use of a carefully constructed measure of an objective kind. Hence it has seemed worth while to analyze the results of the mental tests of a considerable number of persons who came to a psychological clinic for examination because of some deficiency of intelligence or abnormality of behavior. To be sure, there is a special selection of such cases prior to the use of the mental tests, for feeblemindedness seems to depend not only on an intellectual deficiency, such as may be estimated with considerable accuracy with the use of tests, but on much more complicated traits as well, and these other qualities cannot be determined and measured in an exact manner. Hence, the final criterion for feeblemindedness remains a social one, for although persons who are brought to the clinic for a mental examination have already failed in some way, and although they may show an ability less than normal in passing tests, still there is no way of knowing how many persons there are in the community as a whole who have not failed socially, but who, if tested, would show no greater ability than these failures.

The records of nearly four thousand children with intelligence quotients (I.Q.'s)[1] below 90 were classified into groups, corresponding with those described by Terman:[2]

Grade of mental defect	*I.Q.*
Feebleminded:	
Idiot	0–24
Imbecile	25–49
Moron	50–69
Border-line	70–79
Dull	80–89

1 The I.Q. is obtained by dividing the mental age by the chronological age, in the case of a child, while in the case of an adult, the mental age is divided by sixteen, which is regarded as average adult ability on tests. This measure affords a convenient means for comparing defective individuals of all ages.

2 *The Measurement of Intelligence,* by Lewis M. Terman. Boston: Houghton Mifflin Company, 1916. p. 79.

In all, 3,675 individuals with I.Q.'s of less than 90 were studied. Most of them were children, and they came to the clinic from many different sources. Some were brought by relatives and some were sent by institutions such as orphanages, schools, and courts. Most of them were brought because of school failure, but a considerable number were reported as being so troublesome or peculiar that mental abnormality was suspected. Table I gives a classification of the group, according to grade of defect and sex.

TABLE I.—GRADE AND SEX OF CLINIC CASES

	MALES		FEMALES		TOTAL	
Grade	*Number*	*Per Cent*	*Number*	*Per Cent*	*Number*	*Per Cent*
Idiot	30	1.5	21	1.2	51	1.4
Imbecile	110	5.7	120	6.9	230	6.3
Moron	581	29.9	629	36.3	1,210	32.9
Border-line	624	32.2	510	29.4	1,134	30.8
Dull	595	30.7	455	26.2	1,050	28.6
Total	1,940	100.0	1,735	100.0	3,675	100.0

An analysis of this table yields interesting and in some ways surprising results. The totals show the usual proportion—that is, more males than females—brought to the clinic because of some apparent mental incapacity. Defect of the two lowest grades is usually obvious to the most casual observer. Idiots and imbeciles show their abnormality, often by the physical abnormalities that accompany the mental defect, sometimes merely by facial expression, posture, gait, speech, and various other characteristics. Defect of this grade is practically always recognizable without tests of any sort. For this reason it would seem unlikely that any special social selection would influence the appearance of idiots and imbeciles in a clinic. Their mental defect alone would bring them in for mental examination because of school failure and obvious inability to behave as do normal persons.

In the higher grades, there are fewer overt signs of abnormality. Morons and border-line cases are often well-grown and of pleasing appearance, and inferior mental capacity is shown only by persistent inability or unwillingness to adjust to ordinary social conditions. Many habitual delinquents, both juvenile and adult, are of inferior mentality, but, on the

other hand, many offenders are normal mentally, so that lack of social conformity cannot be taken as a test of intelligence as we now use that term. Habitual offenders are being tested in large numbers in institutions and courts, and those whose ability to pass tests is no greater than that of many persons actually confined in institutions for the feebleminded are regarded as subnormal. Probably there is too strong a tendency to ascribe their delinquency to mental defect. But the fact remains that, in the presence of a certain degree of mental defect, little has been accomplished in helping individuals who have failed to learn the need for a degree, at least, of social conformity. In many of the higher grades, mental inferiority has not been suspected until the mental tests were given. This is sufficient evidence that many high-grade defectives escape detection unless they become troublesome and are subjected, for this reason, to special study.

Our table shows a slightly larger number of male idiots than of female. In the imbecile group, there is a slightly larger number of females than of males, and in the moron group a decidedly larger number of females than of males. In the border-line and dull groups there are again more males, although the comparatively small totals of these two highest classes indicate that only a small proportion of those in the community have arrived in the clinic, probably because the border-line and dull person is less likely to become delinquent or to behave peculiarly than is the more defective individual. The larger number of boys in these higher grades may be due to several factors. Less supervision is given to boys in the home, so that they have more opportunity to get into trouble; also more responsibility is placed on the boys by their being permitted to seek work outside of the home, and their defects are therefore more easily demonstrated. The fact that there are more girls than boys in the imbecile and moron groups, however, is not easily explained. Facts at hand at the present time do not account for these figures satisfactorily and further investigation of a much larger number of cases is already under way. A few tentative explanations may, however, be hazarded. It may well be that there are differences in the ability of the sexes to pass certain of the tests and that this difference may account for some of the figures shown. For

example, if boys are better able than girls to pass tests involving the use of numbers, and girls are better able to pass tests of memory, it is quite possible that the very arrangement of the tests may determine the numbers of persons in the various grades.

Another difference in the numbers of the sexes in these grades may be explained by the difference in the tendencies of the two sexes toward delinquency. The relatively prepossessing high-grade girl is far more likely to be involved in sex irregularities than is the equally high-grade defective boy. Sex irregularity on the part of the girls and stealing on the part of the boys form the two most frequent delinquencies met with in the San Francisco juvenile court. It is also true that the intelligence of girls who have had irregular sex experiences is lower than that of the boys brought before the court for stealing.

San Francisco has a very cosmopolitan population. More than forty nationalities were represented in this group of clinic cases and since some occurred in comparatively large numbers, it seemed worth while to study these special groups separately, in order to see whether light might be thrown on this problem. Where both parents were born in the same country, the child was regarded as having the nationality of that country. Table II (page 67) shows the seven largest nationality groups, the American, Italian, Irish, German, Mexican, Spanish, and Chinese.

The first nationality is the American. "American", in a city like San Francisco, means very little. American-born children of American-born white parents are regarded as American, but many of these same Americans retain the customs and even the language of their European forbears to a surprising extent. Hence, American, as used here, must be accepted as a decidedly heterogeneous unit. In this first nationality group, the females exceed the males only in the moron grade. Possibly the manner in which many of this group of girls have shown their defect—that is, by a tendency to sex irregularity—may account entirely for these figures.

In the second nationality group, that of children of Italian parents, the females again exceed the males in the moron grade, although the difference in this case is very small.

TABLE II.—MENTAL STATUS AND SEX OF CLINIC CASES IN SEVEN NATIONALITY GROUPS

COUNTRY OF BIRTH OF BOTH PARENTS	TOTAL			IDIOT			IMBECILE			MORON			BORDER-LINE			DULL		
	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.
								Numbers										
United States	754	676	1,430	16	11	27	54	44	98	205	218	423	247	224	471	232	179	411
Italy	530	413	943	2	4	6	35	29	64	186	190	376	160	81	241	147	109	256
Ireland	59	102	161	1	1	2	0	13	13	16	34	50	22	32	54	20	22	42
Germany	65	63	128	4	0	4	4	4	8	15	21	36	23	25	48	19	13	32
Mexico	41	55	96	0	0	0	1	3	4	16	21	37	11	20	31	13	11	24
Spain	52	37	89	2	0	2	2	2	4	15	18	33	24	13	37	9	4	13
China	49	25	74	0	0	0	1	1	2	20	5	25	14	9	23	14	10	24
Total	1,550	1,371	2,921	25	16	41	97	96	193	473	507	980	501	404	905	454	348	802
								Per cent										
United States	100.0	100.0	100.0	2.1	1.6	1.9	7.2	6.5	6.9	27.2	32.3	29.6	32.7	33.1	32.9	30.8	26.5	28.7
Italy	100.0	100.0	100.0	0.4	1.0	0.6	6.6	7.0	6.8	35.1	46.0	39.9	30.2	19.6	25.6	27.7	26.4	27.1
Ireland	100.0	100.0	100.0	1.5	1.0	1.2	0	12.7	8.1	27.1	33.3	31.1	37.3	31.4	33.5	33.9	21.6	26.1
Germany	100.0	100.0	100.0	6.2	0	3.1	6.2	6.4	6.3	23.0	33.3	28.1	35.4	39.7	37.5	29.2	20.6	25.0
Mexico	100.0	100.0	100.0	0	0	0	2.5	5.4	4.2	39.0	38.2	38.5	26.8	36.4	32.3	31.7	20.0	25.0
Spain	100.0	100.0	100.0	3.8	0	2.2	3.8	5.4	4.5	28.9	48.7	37.1	46.2	35.1	41.6	17.3	10.8	14.6
China	100.0	100.0	100.0	0	0	0	2.0	4.0	2.7	40.8	20.0	33.8	28.6	36.0	31.1	28.6	40.0	32.4
Total	100.0	100.0	100.0	1.6	1.2	1.4	6.3	7.0	6.6	30.5	37.0	33.6	32.3	29.5	31.0	29.3	25.4	27.5

Italian girls are closely supervised and sex delinquency is less common than in other similar social groups.

The Irish group, on the other hand, shows a decidedly larger number of girls in imbecile, moron, and border-line grades: in fact, so great is the excess as to explain to a considerable extent the figures seen in Table I. Tendency to sex irregularity explains a part, but not all of these differences. No valid explanation for this situation has as yet been determined.

In the German group, females still exceed males in the moron grade and very slightly in the border-line class.

In the Mexican group, there are more females in the imbecile, moron, and border-line grades; in the Spanish, slightly more girls in the moron grade; and in the Chinese, more girls in the imbecile grade, but many more boys in the moron and border-line groups. In these last groups, the total numbers are small, but the consistency in all these separate groups is interesting.

On looking over the table, one becomes suspicious that the social factor may account for all of the facts. In a clinic, which is open to all for mental examinations and to which children are brought by parents or guardians seeking advice, it is usually found that some conduct difficulty has first attracted attention to the social incapacity of the child and has secondarily produced suspicion of mental defect. Large numbers of children who are brought to a psychological clinic because of suspected mental deficiency are found, when tested, to have average or better than average ability to pass the Binet test. Some of these last individuals also appear to be hopeless offenders and fail persistently to respond to measures intended to help them conform to required social standards.

These data have suggested the following very tentative conclusions:

First, it is possible, though not probable, that within the group of feebleminded, there are more males at the lowest level, more females in the somewhat higher grades, and finally more males in the highest grade. This theory would require a complex idea of the distribution of intelligence and one at variance with ideas now current. It is assumed, at present,

that the distribution of intelligence represents a normal curve, with its highest point agreeing with average ability and then a gradual decline in both directions, with superior intelligence at the upper end and inferior ability at the lower. This is, however, an assumption that needs further verification.

Second, it is possible that the Binet scale may fail to show true sex differences in children of normal intelligence, but that where mental defect is present, there may be a tendency for slight differences in ability in the two sexes to be exaggerated.

Third, it is very probable that so large a social element, which can in no way be represented by mental-age or I.Q. scores, enters into the appearance of feeblemindedness that tests like those of the Binet scale are not as successful in giving an exact definition of feeblemindedness as we might hope. It is unquestionably true that certain individuals who have all of the characteristics of feeblemindedness as described in general terms of ability and conduct still occasionally make fairly high scores on the Binet scale; whereas, on the other hand, certain persons who have a surprisingly low mental age still succeed in the community under average social conditions. It is even now agreed by all careful clinicians that although the Binet tests offer valuable assistance in the diagnosis of mental deficiency, they must be accompanied by many other aids in determining both the existence of mental defect and the grade of defect present.

MENTAL HYGIENE IN THE PUBLIC SCHOOLS*

IRA S. WILE, M.D.

Associate in Pediatrics and Director of Health Class, Mt. Sinai Hospital, New York City

MENTAL HYGIENE is a term that is frequently misunderstood as referring primarily to the problems of mental defectives. Wherever there is mentality, there is necessity for mental hygiene; wherever there are schools, mental hygiene exists; but there is considerable difference between mental hygiene that is helpful, constructive, and effective and that which is poor, inadequate, and disadvantageous.

Mental hygiene is a generic term that has been made more or less specific in application by individuals interested in various types of problems. Interest in the mentally deficient, the mentally diseased, and the victims of organic cerebral disease has encouraged particular thought about the problems that each of these types involves. The general principles of mental hygiene, however, are applicable to all of them, but are equally applicable to those who are thoroughly normal in their mental potentials and activities. Mental hygiene is merely the science and the art of preserving mental health and of preventing mental inadequacy from any and every cause, so far as may be possible.

It is patent that public schools cannot escape the implications of responsibility contained in this form of definition. Who goes to school? The child. And he goes in his entirety. He goes with his body, his mind, and his soul. He enters the pedagogic precincts to receive what is termed an education; to have facts and processes elucidated to and for him; to acquire training in useful habits that are referable to his muscular system, but equally so to his analytic powers. He

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attends school and learns about the need for the development of ideals that are in moral consonance with accepted human activities and communal living. The entire child is at school.

The school may provide a program of physical education and hygiene, may develop an elaborate curriculum, and may make provision for valuable extracurricular activities, but after all constructive efforts have been made to create a program to meet the needs of a community, the child at school remains the essence of the entire educational system. Whether desired and purposed or not, every element that is placed into a school system has a positive, neutral, or negative value for mental hygienists. The child who is deemed mentally defective and who, therefore, is placed in an ungraded class has received a larger measure of attention than the normal children who surround him. More provision has been made for his physical growth, his mental development, and the releasing of him from handicaps through specific attentions, than has been deemed necessary for the great rank and file of grade pupils. When all is said and done, the end result of the education of mental defectives cannot be compared, in the matter of value to the community, with what is achieved in a similar period of time for normal children.

The school system must recognize that all children are not cast in the same mold. Children present manifold differences in their total activities and in the activities of their component parts. Physical activity may be high and intellectual activity low; social activity may be weak and emotional activity may be strong. The individual child reveals his total reactions at levels that may be higher than that of any component part and at lower levels than any of the higher elements in his nature. Gradation of children in terms of mere chronology or intelligence quotients is, therefore, unhygienic. Schools must recognize that all children present some qualitative or quantitative deviations from the theoretic norms of child structure and function. Mental hygiene concerns every child.

The school has been wont to dwell upon intellectual deficiencies without adequate recognition of emotional disturbances. The school has given far more thought to physical development than to social adaptation. The average school

program of to-day, in the light of our present knowledge, is unbalanced, because it is insufficiently influenced by the principles that are known to affect the personality of school children.

The school child is a multiple organism with a seemingly unitary form. By the very nature of his life, he is both a biologic and a social individual. In his biologic phases, he manifests certain capacities that relate largely to egocentric goals. His intelligence must, to a large extent, be regarded as a biologic part of his existence, a limited instrumentality for acquiring the power of adaptation to life. His social qualities, while they necessarily must take cognizance of his intellectual capacity, are dependent more largely upon the emotional components of his mind, because emotions grow out of social relationships rather than out of intellectual capabilities.

The type of child who is variously designated the difficult child, the maladjusted child, the problem child, presents personality disorders that are bound up with emotional limitations and incapacities rather than with low-grade intellectual powers. Children of superior intelligence, for example, with intelligence quotients above 140, present as large, if not a larger proportion of emotional difficulties than children whose intelligence quotients are below 70. And in the group of dull-normal children, with intelligence quotients between 80 and 90, the larger proportion of disciplinary problems are incidental to emotional instabilities rather than to weakness in educability.

The child at school is in a dual position. He is his unit self, and again he is a unit of any one of a large number of groups, such as his own class, several different departments, and the school as a whole. The variations between individual desires and group demands afford abundant opportunities for emotional distresses and conflicts. The tremendously variable pressures that are brought to bear upon individual children, by single classes or by groups of children or classes, sometimes are of such high degree as to constitute a handicap to their normal development. The blocked personality, the upset emotional equilibrium, may break forth in a variety of actions subversive of the school progress of the individual on the

one hand, and of class discipline on the other. Restlessness, irritability, pugnacity, tearfulness, temper, disobedience, inattentiveness, lying, stealing, and truancy may result from maladjustment in school.

It is time to begin the consideration of mental hygiene, then, in its widest educational implications. Mental hygiene must not be considered as a psychiatric problem, nor should it be viewed only as a mode of treatment of so-called "nervous children", any more than it should be deemed applicable only to the education of mental defectives. As I view the subject, mental hygiene is inherent in every problem of education. Even the schematic development of physical education is permeated with mental-hygiene applications. One must note the interactions between physical and mental welfare, the interweavings of intellectual and emotional reactions, and the dependence of social adaptation upon the physical, intellectual, and emotional components of personality. All of these make it imperative that mental hygiene be linked up with the school system as a whole in a constructive manner. I shall try, therefore, to present a partial program for the development of mental hygiene in and through the public-school system.

As education is a state function, I shall regard my problem as involving a state system of education rather than as merely one that deals with specific or local difficulties.

In the organization of state education, the normal school forms the point of departure for the training of teachers. In these schools a modernization of psychological teaching is needed. The present emphasis upon educational hygiene and methodology should be supplemented by courses dealing with the psychological evolution of children, their types and modes of reaction. Teachers in training should become familiar with the organization of children's educational systems and their emotional-reaction systems. They should receive adequate training in the nature, meaning and purpose, and interpretation of psychometric tests, together with accepted modes of providing and developing remedial teaching.

The normal schools should present the psychological implications of all the special classes. It is not sufficient for teachers to know that there are classes for the near-sighted,

the mentally defective, the anæmic, the deaf, and the crippled; they should also have a thorough appreciation of the hygienic function performed by these classes and their relations to individual needs, growth, and social progress.

In connection with the training schools and model classes, all the possible machinery involved in the application of mental-hygiene principles should be established and should be freely utilized for purposes of training and demonstration. It is unfair to condemn teachers and principals and even city superintendents of schools when the fundamental structure in the educational system is weak and evidences a lack of vision and foresight. The normal schools should be imparting what to-day is common knowledge—that the child as the subject of education is more important than any subject. Discussions as to vertical or horizontal expansions of the curriculum are secondary to considerations of the nature and organization of the children who are to be subjected to these educational policies. Some of the greatest shortcomings along the lines of mental hygiene are to be found in our normal schools and training schools for teachers. And herein must be built the foundation work of whatever mental-hygiene work is to be attempted specifically by teachers in the school systems of the country.

The second step in mental hygiene has to do with the selection of teachers and their proper placement in the school system. Existent methods of merely filling vacancies, without consideration of the adjustment of the individual to the position to be filled, disregard some vital factors. The unhappy teacher or the one who is merely holding down a job or who is teaching a class for which she is unfitted does not provide an attitude or an atmosphere that is conducive to emotional calm. The personality of the teacher in the classroom is always important. Patterns of action, as well as the precepts that appear to be unavoidable, are of consequence in promoting the intellectual and emotional welfare of pupils. It is necessary to protect the mental health of teachers and to enable them to find solutions for their own numerous problems. The interaction of dynamic personalities is bound to result in various types of friction unless some means of smoothing out the situation are found. I would go so far as

to suggest a consultation bureau for teachers to enable them to acquire the mental slant most helpful in the solution of their own difficulties. This would help to develop in them more understanding attitudes toward persons rather than toward actions.

It is necessary that teachers grasp the significance of individuality and personality. Little John is more important than what little John does, even though what he does indicates in part what he is at that particular moment. A large percentage of disciplinary difficulties arise from the failure to recognize the distinction between the offense and the offender.

It is equally necessary that teachers grasp the mental-hygiene potentials of a curriculum. What is the effect of success and failure, complete or partial? What are the effects upon different personalities of rapid-advancement classes, skipping a grade, of demotion, of failure in arithmetic, of slow progress, of inadequate explanations, of weak substitutes, of laxness or rigidity in discipline? What is the relation between character and intelligence? Why does a child fail? What is the nature and effect of a reading deficiency? Which is the more valuable citizen, the dynamic, active, searching child, who may be irritating, or the docile pupil whose behavior is never subversive of the interests of the classroom? To what extent does class grouping modify or affect individual ideas and principles? How far is a smile a pedagogic utility? To what extent should the teacher's home problems be carried into the classroom, even in the form of black clothing? What are the effects upon school children of sarcasm, a loud voice, angry expressions, servility before supervisors, or similar expressions of human relations?

No system of mental hygiene can be successful in the schools unless and until teachers can secure adequate information concerning type problems that involve instruction, discipline, and social organization. To this end traveling teachers' institutes would be of service. The utilization of state or city-directed conferences to discuss specific and general problems would benefit this educational phase of the mental-hygiene movement.

The essence of an educational system lies in the pupils. In

every state the mental problems of children vary according to their rural or urban situation, the nature and intensity of industrial activities, the economic status of the homes, racial characteristics and population density, types of school, and qualifications and tenure of teachers. There are, thus, general and local school problems, the approach to which may be differentiated in terms of civil organization. The large city can create machinery for the solution of its problems much more easily than the very small city, the village, or the rural school district.

There are, however, generic problems of mental hygiene that exist wherever there are children, and these grow out of the ordinary frictions between the biologic creature at school and the social pressures that are brought to bear through the instrumentality of education. The large city may resolve its problem into a series of methods of approach. These may vary for local reasons, but in general they must involve an appreciation of the child as an organized, dynamic being trying to live as whole unit, while learning to function as a unit in the mass. Mental hygiene stresses the child, not as a physical being or an intellectual being or an emotional being or a social being, but as an integrated being who has at least four aspects in expressing his life forces. From the standpoint of such a child, a school system must be shot through with mental-hygiene content.

The facilities available in a large city and in a rural community are distinctly different. Basic for both types of community, however, is a mental-hygiene clinic, whether a mobile clinic supplied by the state, a fixed clinic under the auspices of a public or private organization, or a clinic set up as part of a school organization. Some form of clinical organization is essential for the purpose of studying the problems of children. One so often hears the expression, "the problem child", when one should be discussing the problems of the child. The school has a social responsibility for conducting the biologic child with weak social bonds into a labyrinth of social relationships in which his biologic urges must find an equilibrium.

The psychobiologic child or the biologic-social child cannot depend upon his inherent forces for the satisfactory adjust-

ment of his urges, his desires, and his emotional tendencies. His environment constantly thwarts, modifies, and stimulates his activities. The social influences of the educational system should be employed to aid him in reaching the reasonable stability of maturity without psychic harm to himself and without injury to the groups with whom he must associate.

Any school system, large or small, can make provision for certain helpful arrangements that would promote mental hygiene and lead to a simplification of numerous difficulties that now abound in all school systems. I believe that every child, upon entrance to school, should be ungraded and be placed in a class that might be regarded as a clearing class. In this class there should be an opportunity for demonstrating the probabilities of regular placement. Children should not enter into a class on mere chronology or even in terms of past record. Certain children of the age of six, for example, should not be in school; others belong in a kindergarten; some in the first grade; some in the second grade; some in a class for the hard of hearing; some in a class for the near-sighted; some in a class for the crippled, the pre-tuberculous, and the like, This clearing class, under the direction of the most expert teachers, could within a short period of time determine the primary placement of every child and probably safeguard the child against an unnecessary retardation, an undesirable acceleration, or an unfortunate demotion. Every child in this clearing class should have a careful physical examination as soon as possible, to bring to light physical defects or disease.

Personally, I believe that children who are expected to be ready for admission in September should be examined during the month of June, so that remediable physical handicaps could be attended to prior to school entrance. Though possibly a small number of children might not enter school in September because of death or disability, the number would be negligible. The advantage of such examinations and corrections is obvious and needs no elaborate defense save from the standpoint of those who fear the peak load of examinations at such a time, and who are hesitant about the financial cost.

There would be an advantage in giving psychometric examinations to the same group of children during the month of June, were it possible. The clearing class, however, would

be able to give psychological tests to all the children, and a group test would suffice to differentiate three groups of children—the great modal group of normal, average intelligence, the group of inferiors, and the group of superiors. After transferring the normal group into their proper grades, more discriminatory tests could be given to the superior and inferior groups in order to determine more accurately their probable relationships to the school system. Such a psychological function performed at the very beginning of school life would lead to more careful discrimination in school placement and would provide for more adequate school progress in terms of intellectual capacity. It would give insight early in the school course as to the children who are to be the real intellectual problems of the school, just as it would at the same early time detect those who are to be grouped as mentally defective. To ascertain thus early the group of children with superior intelligence is, however, fraught with still greater significance from the standpoint of social responsibility.

The clearing class would, after a short period of judgment, possess invaluable information with regard to the early emotional reactions of the children. It would be possible, by a coördination of the records of the physical examination, the intelligence status, and the observations of emotional reactions and social tendencies, to get a picture of every child that would indicate much of its personality early in school life.

In connection with this clearing class, there should by all means be a visiting teacher, whose function it would be to supplement the information acquired in this clearing classroom. The information secured from her visits to the homes would supply the facts—social, economic, linguistic, and educational—that are so necessary for interpreting such problems as may arise later during the school life of any particular child.

In addition to the clearing class, I should set up one further school agency—an adjustment clinic. This agency should consist of a conference committee of the school, preferably including the principal and possibly a higher superior authority, the class teacher, and at least one other teacher not teaching the pupil whose problems are to be studied. Discipline should not be meted out for difficult problems without adequate informa-

tion as to the total setting of the child whose adjustment is under question. Discipline is not punishment; it is guidance rather than painful mandate. If available, the reports of the family physician, pediatrist, psychiatrist, psychologist, and all other scientific information should be utilized. The report upon the home, the past record of the child in the school or the court, and even the record of the teacher for bringing up disciplinary problems should be carefully considered. I recall one school, for example, where a single teacher was responsible for more than 50 per cent of all the disciplinary problems that disturbed the principal. As might be expected under such conditions, the teacher was the problem and not the children.

The parents and the child or other children might come before the adjustment clinic without fear or prejudice. The child under discussion might be reported for failure in arithmetic, for falling asleep in class, for fighting, for daydreaming, for unpleasant or annoying behavior in the classroom. The child would receive real attention and some of his needs would be discovered. His offense would be viewed as symptomatic and its origin sought.

The combination of a clearing class, visiting teacher, and adjustment clinic would provide for the reasonable introduction of a constructive mental-hygiene program into the public-school system without great cost. Such a plan could be utilized in cities, large or small, and could be of great service without an elaborate organization.

In communities where psychiatric clinics are available, some liaison between the school and the clinic should be effected. The regular school physician with the responsibility for medical inspection of school children cannot give adequate guidance to the many children who present problems in the public schools. A large number of difficulties that are termed nervous have their origin in conditions that are primarily psychogenetic rather than physical. Many of the difficulties of school children arise from situations in the home and are bound up with neuroses, social maladaptations, emotional distresses, and crises that are beyond the ordinary approaches of school physicians.

It has long been recognized that intelligence may be of tre-

mendous service to the individual and the community. But a high I.Q. carries with it no guarantee of emotional stability or social success and achievement. It is time that the educational institutions took more cognizance of the children who go to school than of the intellectual pabulum that is prepared for them in modern scientific pedagogic kitchens and served in equally up-to-date pedagogic dining rooms.

Character and personality involve more than intelligence. Character represents the main by-product of living, while personality is the sum total of inherited urges and acquired trends. Both personality and character, however, depend upon the development of the emotional life as well as upon the evolution of the intellectual potentials. The physical basis of intellectual activity is fairly well understood, but there is still a great lack of understanding of the emotional conditioning of intellectual performances. The educator is slowly coming to realize that the complexity of the mind constitutes his greatest challenge. The problem of the child is becoming the problem of the school; and the problem of the school is the problem of society. Society's solution of its own problem carries with it by implication the necessary adaptations in school organization so that the problem child will be resolved into two parts—the problem and the child.

THE SINGLE INTERVIEW

E. S. RADEMACHER, M.D.
Psychiatrist, Cleveland Child Guidance Clinic

THE demands for psychiatric service from many different sources in the community so consume the clinic psychiatrist's time that frequent and continuous contact with all the individuals referred to him is impossible. In fact, with many of the cases that come through the clinic, he is limited to a single interview. In many circles it is still felt that subjecting a child to psychiatric scrutiny will resolve all his conflict situations, or, more frequently, that through his mystic power, the psychiatrist will at least find the explanation of annoying conduct or peculiar personality. Such a state of affairs would mark a millenium that has not yet been reached. It is true that not infrequently, in this field of the mental hygiene of childhood, the psychiatrist does meet with an individual who is willing to get at the base of his own difficulty and who as a result discusses the conflict situation that is worrying him at the time. In such cases, however, the willingness of the patient is, perhaps, largely responsible for the unraveling of the warp in the weave. In a single interview this rapport is rare.

Case-workers, school-teachers, interested individuals, frequently refer a child to the psychiatric clinic because "the child is indifferent", "he can't be reached", "we can do nothing with him"; and they add, "It is hoped that the psychiatrist will be able to talk to him and solve his difficulty." Why they have the idea that the child will suddenly throw off his mask of indifference and discuss his troubles with a stranger is not easy to understand. The child is much more likely, at least in a single interview, to show just as much indifference in this new situation as he does in the ordinary ones of his existence. As a result, the psychiatrist has no startling information to present to the worker, and she feels that the contact has been wasted, often giving no considera-

tion whatsoever to other facts that are pointed out in relation to the case because the child has not definitely discussed these facts.

In a single interview, as a general rule, no great amount of subjective material is gained from a child. Even in cases where a child is spontaneous, enthusiastic, and talkative, analysis of the material shows, after all, very little of an actual conflict situation revealed verbally. Often the very verbalism of the patient, while it makes for interesting and lively staff-discussion material, defeats the psychiatrist's attempt to unearth a discussion of subjective attitudes. There are many reasons why this is so. Of importance is the fact that usually such material is painful for the patient to discuss. Only certain types of children derive pleasure from a discussion of their inadequacies or inferiorities, and in such cases these deficiencies are not important sources of conflict. Again, these verbalistic children are so simply because they have learned the value of this method in gaining their own ends. They have discovered the value of verbalizing or becoming circumstantial as a method of evading unpleasant situations or of getting them out of assuming responsibility or putting forth effort toward any accomplishment. In other children verbalism is the essence of the conflict situation itself, in that these children often find adjustment to children of their own age difficult because of their close contact with their parents and their parents' friends. The child knows how to impress adults and attempts to do this with the psychiatrist in his effort to avoid discussion of the unpleasant relationships that actually are his with other children.

There are many reasons why only a minimal amount of actual subjective feeling is obtained from a child in an initial contact. A child who is afraid in new situations is from the start under an emotional strain which does not allow him to converse freely. His responses become stereotyped and his attention inadequate. A child who is apprehensive as a result of some recent misdemeanor will also react to that fear. Usually he will attempt to rationalize his conduct, to show his innocence in the matter, or to place the blame elsewhere. He will spend much time attempting to impress the examiner with his good intentions and his high ideals, and

will not face issues that involve his personal responsibility. The child who comes from a home in which discipline has been repressive is often so suppressed that he is actually afraid to express his feelings on any subject. Often, too, such a child, as a result of his suppression, has no feeling of security in any of his relationships. The home, which may be at the basis of his difficulty, offers the only security that he has, so that he will not readily commit himself in any way that may affect this tie. Children who have been accustomed to overprotective attitudes in the home have difficulty in facing situations that require personal effort. As a result, their behavior becomes of a compensatory or extravagant nature with the aim of bringing attention to them easily. Otherwise, because of a personality molded by oversolicitous care, they are ridiculed by other children. They do not like to face the idea that they are not well suited to meet outside responsibilities or that they are dependent on their parents. At the same time, this very situation is an agreeable one to them and naturally they do not wish to give it up. The responses of these children are often what might be termed "the proper thing to say" rather than an expression of their actual feelings. Problem children from homes in which discipline is inconsistent and highly tinged with emotion realize that notwithstanding the nagging, scolding, or whippings they occasionally receive, such a situation works to their advantage in the sense that they are able to have their own way. Therefore, their responses are quite likely to be conventional or stereotyped ones.

In view of all this, what actually can be gained from a single interview? To say that because so little subjective material is obtainable in a single interview it therefore is of no value, is not true. The very fact that no subjective material is gained from the child is often of the greatest value. The response to the psychiatrist's questioning must be interpreted in terms of social background and physical and psychological make-up. The child who is indifferent throughout the entire interview usually has a definite reason for this indifference and sometimes a careful analysis of the social history will reveal the reason. Possibly such a child is subject to a type of discipline that makes use of impossible

threats or promises profusely in an effort to force him along certain channels. He has learned that the dire consequences with which he has been threatened never materialize. At first they probably caused him worry—a worry that he later found to be needless. Therefore, he no longer concerns himself about it, but becomes indifferent. As to promises, he has probably been placed too often in a position of anticipation and expectancy and later has been disappointed. Not to allow his ego again to become hurt, he again assumes indifference. At the same time, too, he finds this very mask or defense of indifference a source of concern to his parents, so it becomes for him a double-edged sword—on the one hand, protecting his ego and, on the other, gaining him a certain amount of attention and hence recognition. This works equally as well in school or group contacts and naturally is indulged in there also. Underneath this indifference there is likely to be great emotional tension. The problem in treatment, then, becomes an attempt to watch the child closely to find the lever that will lift the mask and to use this opening as a further means of showing him the desirability of more satisfying and adequate emotional responses.

It should be said that relatively few children remain indifferent throughout an entire interview. Usually indifference is resorted to only in situations that are relatively unpleasant. Thus, a child may be talking freely until questioned about his younger brother. Here he suddenly slows up, his attention wanders, his responses become evasive or irrelevant, and his general attitude one of nonchalance. Why has this sudden change occurred unless it definitely indicates that this topic is of special significance in the emotional life of the child? His real feelings are at odds with what he has been taught is socially acceptable; hence he is in a conflict situation. Perhaps he follows with some statement as to his own abilities. Why should this spontaneous remark appear at this point unless the subject of the younger brother has made him feel the need of indicating some superiority? Or perhaps, after lightly touching on his attitude to his brother, he introduces some remark to the effect that his brother can't do things. A spontaneous statement that belittles another individual indicates that the patient's inferiority has been

touched and that he is trying to bolster his ego through this method.

Another child is questioned about his playmates. He at first gives the impression that he has many and follows this by an entirely irrelevant statement. He is avoiding the question of group contact. If brought back, he may say, with much indifference, that he plays with the gang. Why should this child show so little concern about such a fundamental activity of his life if not to cover certain feelings of inadequacy in respect to his adjustment to the group?

Another child is asked whether the other boys like him. Invariably the response is in the affirmative, but even here the manner in which this response is given is important. If he carries conviction with his "sure", and follows spontaneously with adequate reasoning that is proof to him that he is liked, he is probably well adjusted in the group. If, however, he is hesitant or does not answer by saying "yes", but rather "yea" or "uh-huh", this uncertainty is quite likely to indicate that he is on the defensive and is giving what he feels to be the desirable response. The subservient child, the follower in the group may respond that he doesn't know whether the boys like him or not. After deliberation he may say that he thinks they do, and give an adequate reason as to why he should think so. Here he is either being overly modest or is reacting to some feeling of inferiority which does not allow him to say outright that he is liked. The bully type of individual, or the one who always feels badly abused, most often will respond by saying that he doesn't know whether he is liked or not, and if asked what he thinks about it, will again avoid a definite reply and often show a surliness or sullenness in his emotional response. When questioned as to how they know that they are liked by the group, after they have definitely stated that they were, the children who have shown uncertainty will usually have an inadequate answer. One of the most frequent is, "They tell me so." This would be an adequate response for a child not over six or seven years at the most. Children do not go about telling each other, "I like you", beyond the sixth year, to any great extent. Another frequent response is "I give them things." This does not tell anything about the attitude of the group. It does, however, bespeak the possibility

that the child attempts to buy popularity or actually has to buy the group in order to live peaceably.

In discussion of actual misconduct, evasion is the usual response. Children will deny their stealing, lying, truancy, or disobedience, but usually there will be evidence of emotional tension. Restlessness, inattentiveness, vasomotor disturbances, respiratory changes, or even garrulousness or flow of speech on other topics are frequently encountered. When the question of their stealing is put in the past tense, a large number will then admit that they used to take things. This admission is less painful to their ego. Putting things well in the past is less likely to involve them in difficulty, and also they can rationalize with the idea, "I was little then and didn't know any better." When questioned as to when the activity ceased, invariably it is well in the past—"a long time ago". In this connection an hour or a week is sometimes considered a long time in the eyes of the child. As to why they no longer do these things, common replies are, "I found out it was bad", "It didn't do me no good." These responses and others on the same order are ideas derived from adults and are used to impress the examiner with their good intentions. Some say that they were caught and didn't want to be sent away. In none of these instances is there any conception of the personal responsibility involved in the act. When a child is found lacking in this, the home and home discipline should be further investigated. It will not be unusual to find attitudes of irresponsibility in the parents, and a form of discipline not in keeping with mental-hygiene ideas.

Direct lying relative to a bit of behavior is a very difficult thing because of the emotional tension created. As a result of this, the child's story, apparently direct as it may be, often presents flaws which, when pointed out, cause confusion. Witness the flaws in the following interview with a boy fourteen years of age, of a dependent family, who was referred because of stealing, lying, and disobedience. He was also reported as very convincing in his stories. This interview was held at the beginning of the physical examination, when the patient was in the process of removing his shoes and a roll of bills fell to the floor.

Examiner (*picking up roll and handing it to him casually*): Is this your money?

Patient: Er—uh—uh—yea. (*The last word with much emphasis and over-determined surprise. Note the hesitancy or initial retardation, and the uncertainty in his answer, followed by a positive response quite overemphasized.*)

Examiner (*casually and indifferently*): How did you get so much?

Patient: Oh, er—er—I'm holding it for a boy. (*Pause; then quickly*) He's seventeen years old and he works.

Examiner: I thought you said it was your money?

Patient: No—yes—I'm holding it for him. (*Then quickly*) He's seventeen and works and had the money in the bank and wanted to draw it out and didn't want his mother to know about it, so he drew it out and asked me to hold it until to-night. (*Pause; then a change in affect*) He's going to give me a dol—a dollar and a half for holding it. He had it in the bank on Blank and Blank. (*No bank on this corner, but on next street. This slip is of interest in consideration of the fact that the boy is exceptionally well oriented in the city. After the pause, the patient continues again without prompting*) He didn't want his mother to know that he took it out. (*Pause*) He's gonna buy something. (*Casually*) I'm gonna meet him to-night.

Examiner (*casually*): A seventeen-year-old boy, you say?

Patient (*quickly*): Yea, he's seventeen. He works.

Examiner (*casually*): Seventeen-year-old boys ordinarily ask fourteen-year-old boys to hold money for them?

Patient: Yea—er—he's a friend of mine. I met him. He asked me where I was going, and I told him to the Child's Guidance Clinic to see the doctor and get an examination. (*Pause. Note the evasion of the question and also how he switches the conversation to the examination—actually an attempt to please the examiner, i.e., telling another boy that he is coming up to have the examiner look him over. Patient continues*) How soon will I be through, Doctor? (*Continuing to steer away from the issue and showing also an actual desire to get out of the present situation. Without waiting for a response, he adds*) I'm going home and ask my mother if she'll give me ten cents to go down and see Douglas Fairbanks.

He's at the—it's at the Palace—State, ain't it? (*Here again is an attempt to distract the examiner's attention, but also part of his ideation is probably revealed—namely, to attend a show. Incidentally, asking his mother for ten cents to see a show which he definitely knows to be a fifty-cent show is of further interest. Asking the mother—a beautiful way of impressing the examiner with his obedience; and placing the amount at ten cents—showing the reasonableness of his demands.*)

Examiner: Supposing your mother doesn't give you the ten cents.

Patient (*relieved and laughing*): Oh, she will (*with much assurance*). I ask her for ten cents—she'll give me ten cents, all right.

Examiner: But just suppose that she doesn't give it to you?

Patient (*nonchalantly*): Oh, she will. (*Then very suddenly and brightening*) Oh, I know what I'll do—I'll use some of this money. (*Pause.*) That's what I'll do. I'll pay him back. (*Pause.*) Anyway, he said he'd give me a dol—a dollar and a half, and I can take it out of that. I never thought of that (*laughingly*). It's funny I never thought of that. I won't have to ask my mother for anything. I'll just go home and tell her I'm going.

The subject was dismissed throughout the rest of the physical examination, although, with no further questioning on the part of the examiner, the boy kept up a steady flow of conversation. Among various topics, he stated an ambition to be a doctor, asked about the length of time required and the amount of study necessary, and commented on the examiner's youth and intellect. This certainly was an attempt to play up to the examiner's vanity. During the more formal psychiatric interview, the boy discussed the fact that he sold papers and turned the money over to his mother. She gave him the amount needed for his next day's papers and sometimes ten cents. He started playing with a handful of change and became confused in the amount. At this point, he brought out the fact that she had given him some money for lunch and that he had not used all of it, and that this was the reason he had so much left over. Spontaneously he started to give an account of

what he had had for lunch, but could recall only that he had purchased a bottle of pop and two candy bars. In trying to recall the name of one candy bar, he mentioned half the name and questioned the examiner as to what the name really was; then gave it himself. He added that he had taken some of the dollar and a half that was to be his.

At this point the discrepancies of his story were taken up with him. His reply was, "I guess my mother wouldn't believe that either. I'll tell you, Doctor", followed by a long, circumstantial account of his ramblings during the noon hour, and eventually ending with a statement that he had found a pocketbook and taken the money out and come to the clinic. With considerable initial retardation, he named the amount as thirty dollars. He couldn't recall how much he had spent or what he had purchased. He produced the bills and again elaborated as to how he had folded the money and put it into his pocket. It was pointed out to him that the money had been in his shoe, which brought out another lengthy account of his travels and an unfolding of the bills to show how he had rolled them. There were thirty-five dollars in the roll, and when questioned about this he sighed, sank back in his chair, and begged not to be sent away and he would tell all about it. He also pleaded that his mother be not told about it. The total sum of money at length found in his possession was $69.83, which probably accounts for his confusion as to amounts throughout the interview. In regard to his home, he said that his mother had told him that she would disown him if he had any more trouble. This probably connected up with his initial statements relative to the money—*i.e.*, that the other boy didn't want his mother to know that he had it.

In addition to finding out whence the money came, what actually was gained in this interview? The loquaciousness points to long usage of this method of getting around situations. The boy is a better talker than his parents and probably more intelligent, so that it is easy for him to talk himself out of responsibility in the home. He attempts to impress with his good intentions. This, too, he probably learned through use in the home, where it has proved valuable to him. He pleads when in tight situations, another method that has been effectual in his home. His final remark regarding his

mother shows that he is rather insecure in his home, which means that he must constantly compensate in some way in an attempt to overcome this insecurity. He is, however, still dependent on his parents, notwithstanding his various escapades. Discipline in the home has probably been inconsistent and also highly tinged with emotion. Nothing in the way of personal responsibility has been given to him.

Another single interview of quite a different nature shows again how, while little subjective material may be gained, what is secured tends to point the way to an understanding of the conflict situations that are hampering the individual. This was a boy of ten years, another very talkative child, referred because of indifferent school work. In regard to his school work, he replied indifferently, "Oh, my marks are pretty fair", and added, still indifferently, "The highest I usually get is E. This year I got two E's." Asked about his other marks, he mentioned G and F, and then P. More questions revealed the fact that most of his marks were P's. In a haughty manner, he said, "Oh, I didn't like to go. I don't like to sit down and read books and write all day long." Pause; then quickly and with much enthusiasm, "I like to go out and play." When questioned as to what he played, he responded quickly: "Oh, I play the piano and er—er—er—all kinds of games." This last haughtily and in a bored manner. Asked if he played with the other boys, he hesitated and replied, "Well—well—oh, there aren't many in our neighborhood." At school he didn't play with them much, either; this, again, with much boredom. He discussed the fact that they called him names, but attempted to show that this in no way affected him. He added, "I'll have just as good a time playing with girls as with boys, and maybe better, and I'll tell you this much—they don't use half as bad language as boys do." Later he presented another idea: "I like to go out and play, but I just don't seem to go out very much. I like hikes where I'm alone and can do what I want to."

This boy, of high intelligence, but doing poor work in school, remained indifferent to a discussion of school work, but mentioned spontaneously his liking for play. Then when this was discussed, he mentioned first playing the piano, then, as an afterthought and with confusion, the idea of playing with

others, but quickly became indifferent again here. He at first built up a defense for not playing and showed indifference to the fact that he was not liked. Directly afterwards he put much feeling into his remarks about playing with girls, and also defended himself in this on the ground that they were not as bad as boys, later adding that he wanted to be alone. It was impossible to get at his actual feelings in regard to his play life, but certainly he had pointed to his conflict—*i.e.,* his inadequacy in regard to the group and his desire for a more satisfying type of recognition. That this is responsible for his poor school work is quite probable, in that he brought in a discussion of play as a reason for his not liking school, even though he actually had no adequate play life. He probably realized, too, that he could do better school work if he wished. He pointed to this in his method of telling about the grades he received—*i.e.,* that he could get E's and was indifferent if he didn't.

The single interview is of value also because it offers a comparison of one child with others who have been interviewed before. However, it becomes an important element in the examination and treatment of the individual, regardless of the fact that little subjective material is obtained, if the response is interpreted in connection with what is observed in the interview and what has been found through the social investigation.

A child of ten who requires the aid of a chair to reach the examining table, instead of placing his back to it and lifting himself up by his arms, may tell much about his ability in activities that call for physical coördination and strength, but this material certainly should be interpreted in the light of what has been observed by the examiner. The child's whole discussion may be nothing more than wish fulfillment and should be investigated before proper treatment measures can be applied.

Knowledge of the patient's methods of evading the unpleasant may be of value in carrying out treatment in the home in as much as such methods can be pointed out to the parents, so that they will be in a position to help the patient better his adjustment. Although a child does not usually discuss his

conflicts, he frequently gives evidence as to where they exist, so that treatment can be applied where it is needed.

The single interview is a direct and individual approach to the patient. Even though no subjective material may be obtained in verbal expression from the child, other manifestations that point to emotional difficulties are frequently revealed and indicate the individual's need of treatment. Of these various manifestations, any attempt to play up to or impress in one form or another, any over-determined responses, any bits of circumstantiality or hesitations, any restlessness, inattentiveness, changes in emotional attitudes, vasomotor or respiratory disturbances, should be considered and interpreted in the light of the subject's history, his physical and psychological state, and his past background. With such an interpretation, it is possible to put into effect an adequate treatment plan.

ARE THE FEEBLEMINDED CRIMINALS?*

GEORGE L. WALLACE, M.D.

Superintendent, Wrentham State School, Wrentham, Massachusetts

BEFORE the method of mental measurement by tests was discovered, the English commission appointed to study the problem of feeblemindedness in England defined a feebleminded person as one who, "on account of mental defect occurring at or after birth, is incapable of competing on equal terms with his fellows in the station of life to which he is born".

According to this definition, failure in social adjustment is the determining factor in a diagnosis of feeblemindedness.

To-day, standard tests for measuring intelligence have been generally accepted and are widely used in making this diagnosis. All persons subjected to this examination whose mental level falls below 75 I.Q. are classified as feebleminded. There are a goodly number, however, who have escaped this examination, of whom there is little doubt that their mental levels fall below this arbitrary line, yet who are well adjusted socially and who are, therefore, not classed as mental defectives. With the tendency at the present time to give still wider application to the mental tests, it is probable that in the future but few will escape them. These tests answer, in a way, the desire to reduce everything to measurements and classification. They represent the effort toward making the incomprehensible comprehensible and the intangible tangible, yet the elusive qualitative something that gives the ego individuality and distinction has resisted all attempts to place it within quantitative confines.

From the earliest times, there has been a persistent effort to evaluate the mental and social manifestations of the human race in a quantitative and material way. For instance, very early we find the sheep separated from the goats. As we

* Read at the Conference on Mental Factors in Crime, Boston, May 18, 1928.

progress, however, toward a better understanding of the many factors that make for social adjustment, a comparative evaluation will no doubt be evolved in which the findings of mental tests and social reactions will be more equally emphasized in arriving at a determination of human abilities. It is quite possible that in the future the line between normal and feebleminded, as indicated by the I.Q., will become more variable, that the point at which it is set will depend upon the individual case, and that proper evaluation of the emotional reactions of the individual will be given greater importance in drawing the line between normality and abnormality. Before the discovery of the moron through the application of the intelligence tests, the number of the feebleminded was estimated as one or two per thousand of the population; now the number has reached two or three per one hundred of the population. When the classification of the feebleminded included only idiots and imbeciles, the term "criminal" was almost unknown in the field of mental deficiency. It is this moron group that has given the feebleminded their bad name, as it is within the moron mental levels and, in fact, among the highest grade of this class that most of the criminals among the feebleminded are found.

If feeblemindedness of itself is a cause of criminality, why should the two not appear in direct ratio? That is, why should not the greater percentage of criminals be found among the lower grades of the feebleminded? As a matter of fact, the exact opposite is true. Early surveys of the mental ratings of delinquents and criminals were startling in the high percentages of feebleminded found. In some instances, the findings ran as high as 75 and 80 per cent in the population of reform schools and jails. Later surveys, however, modified these findings and reduced them to 15 to 30 per cent of feebleminded in the delinquent and criminal class, which, of course, is still high.

Before admitting, however, that the feebleminded as a class are criminals, we should consider certain important factors that have a direct bearing on and should modify these disproportionately large figures. First, the number of individuals in the general population whose mental levels, if obtained, would place them in the feebleminded group is

undoubtedly large. Then, also, as has been pointed out by various observers, the greater number of the feebleminded who are pursuing social activities contrary to the law are quickly discovered, while it is probable that only a small percentage of persons of normal intelligence who are engaged in similar antisocial activities are ever discovered. The feebleminded girl who indulges in illicit sex practices always gets into trouble one way or another and is usually early discovered; the girl of normal intelligence similarly engaged is infrequently discovered. A feebleminded person who commits a burglary usually bungles and is promptly brought into court; the normal individual is generally able to carry on his burglary for an indefinite time before discovery. It must be remembered that many of the feebleminded who come into conflict with the law are simply pawns operating under the direction of persons endowed with normal intelligence. In the gang all are much more expert in eluding pursuit and detection than is the feebleminded person who has been used as the pawn. When apprehended and brought into court, the feebleminded usually have no influential relatives to intercede for them or wealth to enlist in their defense. It is, therefore, quite fair to conclude that a larger percentage of the feebleminded find their way into courts, and a larger percentage are convicted and sentenced, than of the mentally normal who are haled into court for similar offenses. When once within the correctional institutions on account of their faulty judgment, the feebleminded are not likely to be favorably considered either for parole or as individuals who would benefit by the minimum sentence. Hence this residue within the correctional institutions raises the percentage of feebleminded present at a given time.

It is obvious, therefore, that it would be unfair to draw the conclusion that the feebleminded as a class are criminals simply because of the relatively large number of feebleminded who come into conflict with the law and who are convicted and are in correctional institutions. Most of the feebleminded are leading industrious, honest lives. The feebleminded as a class are endowed to a greater degree than individuals on the higher mental levels with the desire to please those with whom they associate. This very virtue proves to be a liability

for the feebleminded, and is one of the reasons why so many of them come into conflict with the law.

There is little doubt that most of the feebleminded who become criminals do so by accident rather than by intention. There is little doubt that the larger number of the feebleminded who are criminals belong to this class and may, therefore, be designated as delinquent defectives—that is, delinquents in whom the mental defect is the major abnormality and the cause of the victim's coming into conflict with the law. There is, however, a class of criminals among the feebleminded who, though few in number, are none the less important and should not be confused with this large class of delinquent defectives. The class to which I refer is the defective delinquent. In this group the delinquency is the major abnormality and the mental defect secondary. In other words, while the greater number of feebleminded who are criminals are passively so and are so largely on account of their environment, this relatively small group of defective delinquents are actively criminal and are so either in harmony with their environment or in spite of their environment.

There are thousands of people whose mental levels, if ascertained, would place them within the feebleminded group, yet who have adjusted well in the community and who are real assets to society in the type of work they perform. I do not offer this in the way of placing a premium on a low scale of intelligence as a means of providing necessary workers for certain grades of work. On the contrary, I believe a civilization that is farseeing enough to adopt measures which will reduce mental deficiency to the minimum can be relied upon to invent machinery that will make unnecessary the menial type of work performed by people of low intelligence and at the same time will dignify all necessary labor.

Who, then, are the feebleminded that are making the trouble by coming into conflict with the law? They are the socially maladjusted; they are exactly the same classes that are making the trouble on the higher mental levels; they are pathological liars, thieves, rovers, bunkers-out, psychopathic personalities, neurasthenics, and individuals suffering from laziness, brain storms, inferiority complexes, temperamental episodes, emotional instability, and the like.

If two cross sections of the population could be studied from a psychiatric point of view with the object of ascertaining what material it is that makes for positive, active criminality, it is doubtful if a greater preponderance of that material would be found in the section of the population whose mental levels are below a 75 I.Q. than in the section whose mental levels are above 75. The feebleminded, quite in common with the rest of the population, have two kinds of intelligence—mental intelligence and social intelligence, the only difference being that the mental intelligence in the feebleminded is not on so high a level. It is the balance or imbalance, however, of these two intelligences in the individual that makes for social adjustment or social failure on all mental levels. When both are working in harmony, the individual is able to take his place as a well-adjusted member of society. When they are not working in harmony, the individual is poorly adjusted and usually becomes a social problem. But it is the lack of social intelligence rather than the lack of mental intelligence that causes the individual to come into conflict with society. There is little doubt, however, that a larger percentage of the population with a mental level below 75 I.Q. is found in conflict with society—that is, is actually convicted or brought into court—than the percentage found in the population on a mental level above this I.Q. The knowledge of this fact should be a sufficient reason—indeed, should be a challenge to all concerned—to study the criminal problem on these lower mental levels. There is little doubt that the roots of antisocial conduct are planted in childhood. The feebleminded child, being more plastic and less self-reliant, is even more dependent on his environment for his social training than is the normal child.

We are beginning to realize how important child training is—how important it is that children form proper habits of thought and action. The recognition of the importance of this is being emphasized by the establishment of child-guidance clinics for children of all ages and habit-training clinics for children of pre-school age. The purposes of these activities is to assist the child to adjust properly to society. If these efforts are necessary in the case of normal children,

surely greater efforts should be made toward the proper social adjustment of mentally retarded children.

There are a large number of feebleminded adults who are not properly adjusted socially and who are causing much concern and anxiety to the various social agencies. There are a large number of feebleminded children who are not properly adjusted socially and who very soon are going to be not properly adjusted feebleminded adults. The badly adjusted group in society must furnish the largest number of criminals. Therefore, if the number of criminals in the future is to be restricted, should not these badly adjusted feebleminded children have careful consideration?

In the field of psychology, much has been learned of normal psychology from the abnormal psychology of the feebleminded. In the field of education, pedagogy owes much to the methods employed in teaching the feebleminded. If proper attention is given to the problem of feeblemindedness among the criminal class and if active means are instituted to improve the social training of feebleminded children, are we not justified in prophesying that in the future the science of penology also will be indebted to the feebleminded?

PERSONALITY AND THE SOCIAL WORKER

HELEN I. CLARKE

Assistant Professor of Social Case-work, Department of Sociology, University of Wisconsin

LIKE most other good words, "personality" has been cheapened by easy and unthinking usage. We need not, however, necessarily banish the word from our vocabulary on that account, but rather should articulate our particular meaning. Case-workers believe that the development of personality is the essence of their profession. What do we mean by it? How do we develop it? When can we recognize the accomplishment?

If we are to concede that development of personality is the aim of the case-worker, we ought to agree also upon a definition of what personality is and the technique by which it can be studied and its growth fostered. The truth of the matter is, however, that there are almost as many conceptions of what personality is as there are people thinking on the matter.

Most people would perhaps define personality very much as did Professor E. A. Ross in a recent conversation. He described it as "that quality which makes people more or less unpredictable". This is the meaning in the press and in current usage. Such adjectives as "tantalizing", "elusive", "magnetic", "dynamic", "irresistible" are illustrative of the terms used to describe the individual who has a fascination or appeal because we are not too sure of his reactions. Paul Robeson, a Negro singer, actor, lawyer, honor student, has personality. Of him Elizabeth Sergeant has written in the *New Republic:* "Perhaps nobody has done anything for Paul Robeson but God Almighty who gave him his simple, beloved personality." Robeson is thus presumed to be possessed of the brilliant and the unusual by the behest of the good Lord. E. Barrington, writing her imaginary tales of "The Ladies", says in her preface: "The aim of these stories is not historical exactitude. . . . They are rather an attempt to recreate the personalities of a succession of charming women, ranging from Elizabeth Pepys . . . to Fannie Burney."

The person, then, who avoids stereotyped and conventional modes of behavior, who is original and creative,who is unexpected and surprising, who has peculiarities and idiosyncrasies, is the possessor of personality. If he is negative or neutral or ordinary or bromidic, he lacks personality. How can the social worker or any one else working with people hope to analyze personality, and then control and develop it, if it is unpredictable, elusive, and just out of the range of comprehension? This is a perfectly good and valid meaning of the term, but personality as the undefinable and unanalyzable in human beings is not a concept that can have scientific import.

Some people, in defining personality, make it synonymous with character or give it the meaning that it seems to me "character" should have for scientific purposes. Watson has said: "Popularly speaking, we would say that a liar and a profligate had no character, but he may have an exceedingly interesting personality." Mrs. Mary Willcox Glenn, in a paper delivered before the conference on "The Family" in Buffalo, talked of "helping men individually to maintain and develop their essential character—their personality".

Dr. Morton Prince has written: "The terms personality and character are often used interchangeably as synonyms. It would be better to use 'personality' in the comprehensive sense for the sum total of all the enduring traits and their underlying organized dispositions, potential and active, innate and acquired, possessed by the organism, and reserve 'character' for those traits and dispositions which are pre dominant or characterize the personality at different moments, determining at such moments the reaction of the organism."

In a most interesting lecture delivered before the Wisconsin chapter of the Alpha Kappa Delta, Professor Edward Sapir of Chicago gave his conception of personality. He feels that personality is often fixed by two years of age; that environment and heredity have played their part by that time and that the fundamental personality characteristics of introversion and extroversion are well defined. This type of personality, Mr. Sapir says, is discovered largely by intuition.

All of these definitions and conceptions of personality are useful for one purpose or another. But the function of the case-worker is to develop personality; if the working defini-

tion of personality implies that such a change cannot be accomplished, it would be foolish for the social worker to set herself that goal. Instead of thinking of personality as more or less fixed, and character as easily changing, I prefer to think of personality as an entity capable of change and of being changed, and of character as being more or less stabilized, changing only as the integration of the dominant personalities changes.

This point of view is best defined by Professor Park: "Personality may then be defined as the sum and organization of those traits which determine the rôle of the individual in the group." By traits are meant physical and temperamental characteristics, prestige, the individual's conception of his own rôle, and his social expressions and gestures. Character is organized personalities, and the process by which organization occurs may be conscious and involve emotional struggle, or more or less unconscious and involve a minimum of intellectual and emotional strain. Character is integrated only in so far as the personalities of the individual do not conflict. This last conception of personality is one that can be used in the scientific analysis of people and their behavior.

The literature of novel and stage is filled with illustrations of conflicting personalities within the individual, of the resulting more or less integrated or disintegrated character, of the effects such people have on their groups, and of the effects the groups in turn have upon the individual. In Suderman's *Magda,* the father plays one rôle in his family and another with his veteran war cronies. In the name of love he tyrannizes over his family, and Magda alone refuses to be dominated. The tragedy of the play is that the father, unable to change his behavior and attitudes in the family group, pushes Magda out of the home. Had he been able to adjust his conception of himself to his two very different daughters, he would have avoided tragedy both for himself and the others of the family group. He could not conceive of himself within the family except as the benevolent despot, and so, although with his army comrades he was the gentle and understanding friend, in his home he continued in his rôle of dictator and tyrant.

Bromfield's "good woman" cannot forget her own interests long enough to understand her son and his wife. Her rôle in

all groups is that of a virtuous, high-minded woman who shrinks not at all from her idea of her duty and who will let nothing interfere with her smug self-satisfaction. She avoids tragedy for herself because she consistently organizes a rigid, selfish character, but her inflexibility brings tragedy to those whom she pretends to love best. Phillip, the son, eventually pulls himself from under his mother's influence, but he is never able to reconcile his various personalities; his character integration or self-realization comes only as he faces death.

It is impossible to read *Jalna* or *The Grandmothers* or *The Buddenbrooks* or *The Syrian Christ* or Cellini's autobiography or a life of Abraham Lincoln without feeling that the various social groups known to the individuals in question had a tremendous effect upon the many personalities of each of those individuals. It is probably no exaggeration to say that an individual has as many personalities as he has groups or social contacts. Our attitudes and behavior vary tremendously with different groups. A man is a different being to his valet and to his business partners, to his wife and to his mistress, to his priest and to his gambling partner. From each of these contacts he derives different impulses which, taken together with his inherent traits, form a different personality.

Certainly I am not the same person when I am applying for a position as when I am consulting an applicant; nor am I the same person when I am teaching as when I am being taught. The troublesome and incorrigible child is not the same youngster with his father, who projects his standards of scholarship upon his son's unwilling head and spirit, as with the active, virile, and athletic school-teacher, who has little interest in sonnets or lyrics, but much in the high-school football score. The habitual runaway from an institution is a very sadly different child when telling of his imagined mistreatment to a would-be benefactor than when promising his matron to be "a good and grateful boy forever and ever, honest to God". The adolescent girl in the hated foster home who develops severe hysteria is surely not the same person as the winning and gracious young hostess in the family where appreciation and consideration are given her.

Some one has said: "It is in each man's social relation-

ships that his mental history is largely written." If the personalities of each individual are largely given him by his groups, his character is nevertheless pretty much his own. Few of us, however, organize our many personalities into an entirely consistent whole. Recently I was much impressed with the attitudes of a very plain, but extremely winning normal-school teacher of opportunity-room technique. She presumably has not been without her conflicts, but she seems to have developed a peace of mind which enables her to look calmly and objectively upon herself, the world, and its occupants. She has her opinions, but she has them calmly; she may have her turmoils, but she does not inflict them upon her associates. Character organization varies all the way from the seemingly smooth and serene life of this normal-school teacher to that of the hysterical, psychopathic, or insane person who faces reality little or not at all. We are entirely accurate when we talk of split, inconsistent, heterogeneous, discordant personalities. The man paralyzed by day and a roof-walker at night certainly has not achieved a unified self. Lady Macbeth suffered the tortures of a criminal unable to reconcile her behavior and her ideals when she said in her sleep-walking: "Here's the smell of blood still; all the perfumes of Arabia will not sweeten this little hand."

Unlike Humpty Dumpty, who after his great smash could never be put together again, it is often possible for the person himself, the physician, the social worker, the friend to reconcile attitudes and acts and to produce or to help produce a harmonious whole—an integrated character. Jane Hillyer has "reluctantly told" of her insanity and of the eventual reconciliation of her various personalities to one another. Every true friend at some time helps a disturbed friend overcome his difficulties, change his attitudes, gain his courage.

It is the main function of the social worker to assist in the development of new attitudes which in turn foster new personality manifestations and which may give the individual the impetus to reintegrate his personalities into a more healthy whole. It seems to me that a social case-worker could not aspire to a nobler aim than to give maladjusted individuals an opportunity to enjoy the freedom which Professor J. K. Hart has defined as "the chance to mold your own discipline from within". Group contacts may be changed, the physical and

social environment may be changed, but the case-worker has not fundamentally developed the individual's personalities if she does not prevail upon him to mold his discipline from within.

Have we perhaps agreed that the aim of the case-worker is the development of an individual's personalities and that by personality we mean something that is different with each contact? If so, it seems to me next necessary to determine a technique by which personality can be analyzed. It is hard to analyze something that constantly changes, but I believe it is not impossible to devise a technique for adequately understanding and then remolding or redeveloping personalities. That social workers have been successful in this development is a credit to the intuitive processes of the human being, for few would deny that there is little of the scientific in their understanding of what personality is, of how it is formulated, or how it is to be dissected and studied in order to be reorganized and to be eventually integrated with all the other many personalities of the person concerned.

We observe that we gain certain ends at one time by the use of certain strategy and that we do not gain the same ends in different circumstances by the use of the same methods. If the anger of one person is allowed "to run down", we gain rapport; if the anger of another is allowed to proceed, it gains momentum and prevents ultimate coöperation. Condoling with one grief-stricken parent brings consolation and with another aggravation of the grief. Remonstrating with one obstreperous lad brings realization of the error of his ways and with another a negative suggestibility and a fixation of his ways. If we deliberately become irate with a deserting father at one time we affect him with fear and he supports his family; at another time, with resentment and he runs away. The truth of the matter is that we can treat no two people exactly alike and that the same person cannot always be approached in the same manner.

Whether we use Professor Park's or Professor Ross's definition of personality, we are forced to admit that it is a changing thing. By Professor Ross's definition, it is a changing whole capable of description. By Professor Park's definition, the parts of a whole are changing and those parts are capable of analysis. We can describe a person whose

personality is interesting and God-given; we can analyze a personality that is made by its contacts. A social worker cannot change a volatile or enticing person, but she can hope to change a personality made by the welding of inherent traits and group contacts.

One-armed Mr. Perry had been spoiled by social workers and he had developed a dependency attitude. He was accustomed to having things given to him easily. One day an energetic and positive young social worker entered his home and told him he would receive no more assistance unless he took such positions as were available and unless he had the badly diseased tonsils of his children removed. He refused and replied that he was capable of managing his own affairs. Later another young social worker, persuasive, charming, and intelligent, talked with him about the necessity of caring for his children's health. She did not browbeat him, but talked with him as a gentleman and as a friend. His attitude changed and he gave permission for the tonsil operation. The personalities manifested by this man toward the two social workers were very different. One social worker took pains to study his past and present traits, his past and present group contacts, and his own conception of himself; the other did not. One succeeded in changing his personality manifestations; the other did not.

At present the social worker tends to watch the overt behavior of an individual and continues or discontinues her method of approach according to the reaction. In our early contacts with a client perhaps this is the only thing we can do because we have not yet been able to analyze his many personalities. But we can proceed with our accumulation of data in such a way as to be able to understand better than we now do the many personalities of the individual and the resultant character.

It is, therefore, necessary that we make two main analyses of any given problem person. First, we must acquaint ourselves with his most important personalities, which involves knowledge of his social groups, his previous experiences, and his inherent traits; second, we must ascertain what his character is. How can this be done?

To understand the client's personalities we must (1) observe his overt behavior in varying circumstances; (2) observe the

groups in which this behavior is manifested, both when the individual concerned is a part of the group and when he is not; (3) obtain the subjective reactions of the individual with regard to his behavior within and toward these groups; (4) obtain the reflections of the group toward the individual and his behavior, both within that group and elsewhere; (5) obtain the reflections of the individual concerning what he thinks the group is thinking; (6) obtain from available groups, tendencies with which the individual was probably born and traits that have developed with his acquisition of status.

Social workers are already securing such material more or less, but its value is limited by the use to which it can be put, because of our misunderstanding of what personality is. From such information we should fairly well be able to understand why an inebriate can control himself at certain times and cannot at others; why a naturally peaceful and docile person occasionally becomes furiously and uncontrollably angry; why that same person as a result of such an outburst becomes morose and despondent because of the conflict between his ideals and intellect, behavior and emotion. We understand why with some people the teacher is dogmatic, with others servile, with others positive, but not unwilling to be convinced. We comprehend why a father is a jolly good fellow on the job, a tyrant in his home, a pious deacon in his church, and a debauched alumnus at his college reunion. These many personalities within one person are the result of contacts with groups, of preceding experiences, of innate and acquired traits; they are the individual's rôle at a given time.

In addition we must ascertain the person's character, the way he has integrated his various personalities. To do this we must (1) observe enough of his behavior in several groups to see how consistent or inconsistent his rôles are; (2) obtain the statements of others as to whether or not his behavior is consistent; (3) obtain his own statement as to whether or not he fulfills his own conception of what he wants to do and be.

If a man is described by his friends and family as being an amiable, hard-working, God-fearing person and his behavior seems never to have deviated from this program, he would presumably have little conflict between his various per-

sonalities and would be called a well-organized person. If, on the other hand, this same man suddenly deserts his family and wife for another woman and recognizes that he has done wrong and would have done otherwise, but will not return voluntarily to his legal family and obligation, there is manifested a great conflict between his various selves, and the resultant character formation is that of a vacillating, weak-willed, flabby-minded man who has conformed to the mores and seemingly reconciled his behavior manifestations only because there has been no strong incentive for doing otherwise. Tolstoi, St. Augustine, the converts in Begbies *Twice Born Men* were not the same after conversion; their character organization was very different.

Most of us have conflicting personalities and a resulting character organization that is imperfect; most of us, however, do not have such conflicts that we are compelled to consult other than our friends in order to effect a reasonable adjustment. Not all of the individuals who seek out or who are sought out by social agencies present such problems that a detailed personality analysis of the type described above is necessary.

When, however, a social worker says to herself that her main task in a given instance is to produce new attitudes, opposite behavior, a different intent, fewer conflicts, she should assume that she must make a detailed analysis of the many personalities. When such an analysis has been made, she is in a position to say what she believes to be wrong with the individual and his social environment and can then proceed to outline a program of treatment which, on the basis of her analysis and previous experience, she hopes will bring about the desired growth of personalities and resultant character. As social workers, we expect too much. We want regenerated characters. We might very well say to ourselves that it is impossible to change the characters of many of our adult clients and remove from our ideals a program which in our reflective moments we know to be impossible. We can help to change some of the personalities of some of our clients and at times help them reintegrate their personalities into a better whole. Let us not, however, attempt the impossible.

SOME PHASES OF COOPERATIVE CASE-WORK *

GOLDIE BASCH

Coöperative Worker, Philadelphia Child Guidance Clinic

IN developing the service that a child-study clinic may give to a variety of non-psychiatric agencies in one city, several major problems confront the psychiatric worker, especially when the city in question already has its psychological and psychiatric resources, and when its social agencies represent many different stages of development as regards training, background, and interests of their workers. As a newcomer to the community, the clinic has much to learn in adapting itself to a scheme of things already well worked out. Chief among its considerations is that of determining what contributions, if any, the clinic has to make to these social agencies. It has next to determine how this contribution can best be made to the community scheme already established, without seeming to duplicate the work of others; how the clinical set-up can best be adapted to the widely varying needs of different agencies; how to establish, as quickly as possible, a genuine understanding between clinic and coöperative agencies, so that each can profit by what the other has to give; how the clinic may demonstrate, through its coöperative service, the genuine appreciation it feels for the good work already being done in various fields.

Experience seems to indicate that an experimental approach to these problems is the most desirable. From such an approach there may gradually evolve the flexible type of service that seems to have proven practical and constructive. A service of this kind means that the psychiatric worker undertakes a thoughtful and sympathetic study of the other

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agencies' resources and handicaps, so that the procedure of the clinic can be made most easily applicable to their needs and interests. As a basis for establishing progressively good relationships with a given agency, the psychiatric worker should learn something about the amount and type of its case load, the intensity with which it deals with the general run of its own cases, its ambitions in the matter of training for its own workers, the conception it holds of its own place in the community scheme. Knowing something about these matters, and having an understanding attitude toward them, the psychiatric worker can do much toward helping the clinic realize the satisfaction of seeing its work appreciatively received because it has been interested in understanding, not only the problem child, but also the situations that confront those who are trying to work with the problem child. With this interest in mind, a coöperative service individualizes in terms of the agencies and their workers, as well as in terms of the children referred by them.

The clinic worker's contacts with the coöperating agency are usually of two types. There are, first, general discussion with workers and executives on question of policies, relationships, and the like. These general contacts are especially helpful to the clinic worker in orienting herself in a new city. Second, there are the contacts made in connection with individual case studies. Perhaps the most useful of these is the discussion with each worker who for the first time refers a case for study. Both types of contact—but perhaps especially the individual talk with the new worker about to refer a case—can be so planned as to yield the maximum of mutual understanding. On such an occasion the psychiatric worker can outline briefly the clinic's general procedure; she can indicate its place in the community as differentiated from other resources this worker may have used; she can mention the nature of the clinic's interest in such matters as a long-time-treatment approach to a case, rather than a brief diagnostic method of handling it; she can, if it seems advisable, touch on the gradual process of reëducation that treatment involves, and the great infrequency of magical results; she can express the clinic's wish to develop its study, its conference procedure, written reports, and follow-up plans so that

they will be of the greatest use to the coöperating agency. This policy of adapting the clinic to the agency's needs—of being, in a sense, the agency's clinic so far as the coöperative case is concerned—implies that the case under discussion remains the agency's case—that the coöperative work is to proceed with the understanding that the clinic is interested, not in assuming the leadership or the chief responsibility in the undertaking, but rather in lending itself to whatever procedure will help the agency handle its own case. This understanding between clinic and coöperating agency is one that may assume a primary significance in determining the type of community relationships that the clinic is to establish.

Perhaps the case being referred is one to which the clinic study can add little of value, either because the situation is one with which the clinic is not equipped to deal, or because the referring agency itself has, after long and thorough work, accomplished as much as could be accomplished for the child and his family. A case of this kind lends itself well to the discussion of such points as the tentative limits that the clinic places on its usefulness; what cases it conceives of as belonging to other psychiatric or psychological resources in the community; or its appreciation of the thoughtful child-placing or family case-work that has already brought about constructive results, to which psychiatric service could at the time in question add little.

If, on the contrary, the case seems one that could profitably be studied, the social history that the outside worker is being asked to supply can be discussed in as much detail as seems indicated, so that she may have an opportunity to ask any questions or make any comments she wishes in regard to the history outline. A rather tentative discussion of this outline in terms of the case in question will, it is hoped, send the coöperating worker away with something of a zest to find out a little more about this problem child, rather than with the feeling that the clinic wants an overwhelming amount of information. By welcoming the agency worker's comments on the entire clinical procedure; by being interested in her experience, or lack of experience, with cases similar to the one referred, as well as in what she has already tried to do for the child and what she would like to learn about him through the clinic study—

the psychiatric worker may learn what aspects of the prospective case study are most likely to be of use to the agency worker.

An interview of this sort, taking place before the clinic and the referring agency have incurred any responsibility toward each other, has seemed one of the most helpful means of establishing a sympathetic sort of coöperation. A series of such interviews between the psychiatric worker and various individuals from any one staff, as each one brings her cases for study, has a cumulative value to the clinic in that it indicates what trends are being followed by the case-work in this particular agency. Also, there is a question as to whether a coöperating worker, after a talk with some one connected with the clinic who shows a friendly interest in her job, may not more easily identify herself and her case with the clinic study than she might otherwise have done.

Having by these means gained some general idea of the outside worker's type of interest in her problem child, and to what extent mental-hygiene concepts are already part of her equipment, the psychiatric worker is in a position to act as a liaison officer between the outside agency and the clinic staff of psychiatrists and psychologists. Most members of a psychiatric examining staff have had few opportunities to become acquainted in detail with the problems that present themselves to the various social agencies, and, on the other hand, most social workers are exceedingly eager to obtain what the psychiatrist or psychologist has to offer. If the psychiatric worker's experience with the agency is used to plan the clinic's contribution in such a way that it will result in the practical working out of case problems, the carrying of coöperative cases may become to the psychiatrist or psychologist an undertaking of double satisfaction. He will find his work appreciatively received, not only by problem children and their families, but also by an increasingly large group of social organizations. The psychiatric worker may, for instance, plan with the examiners so that the conference discussion will present the material most likely to be of value to the agency; she may, with her knowledge of the agency in mind, help to prepare the written reports that go out, so that, by means of arrangement and type of detail, they will

stimulate interest in the fresh aspects brought out by the case study.

By way of illustration, one worker referred the case of an eight-year-old girl, very much beyond the control of her mother, whose widowed condition, poverty, and frail health had made a strong appeal to the worker's apparently sensitive and sympathetic make-up. This identification of the worker with the mother could be glimpsed when the case was brought to the psychiatric worker for reference to the clinic. Before the case came up for joint conference with the agency, the psychiatric worker was able to pass on to the examiners the results of her contact with the agency worker. Upon examination, it seemed that the patient's undesirable behavior was probably the result of her jealousy of the mother's attention to an older sister, and possibly, too, of the mother's attention to the worker; also, to the mother's conviction that the patient was a bad girl. But to have stressed this interpretation at the conference might very well have caused the worker to stiffen—perhaps unconsciously—in defense of the mother, and she might easily have concluded that the clinic after all could not understand—it hadn't seen Lillian in action. With such a contingency in mind, the conference was planned so that the psychiatrist could speak in general terms of the problems of a widowed mother—how naturally she turns to one of her children for emotional satisfaction, how easy it was for Lillian to have become the less lovable child because of her early illnesses and irritability, and how much an intelligent mother of this sort could do for a child of Lillian's possibilities. With little further activity on the part of the clinic, the agency worker carried out the treatment suggested by the discussion at this one conference, and Lillian's favorable response was encouraging both to the family and the agency.

The intensity of the case study is another matter that the psychiatric worker may wish to consider and to some extent may be able to control. She may, for instance, encourage certain agencies to refer cases that lend themselves to a rather brief, less intensive study and treatment. A series of such cases, brought by one worker, is often of more help to the outside agency, and may promote better coöperative relationships, than would one case exhaustively followed. The

one case might, in view of the agency's heavy case load, seem very expensive of time and energy, and the returns from such a case, however good from the clinic's point of view, might justly seem of relatively small value to the agency. One worker brought to the clinic two or three cases, in each of which the problem was chiefly that of a rather dull boy, reacting badly to a school grade too advanced for him and getting into more and more trouble outside school because of truancy and subsequent loss of status with his own family. Ordinarily, one might hesitate to accept such cases, in which intellectual subnormality seemed so large a factor, for a complete study. The clinic worker, however, having learned something of the agency worker's situation, thought that these cases might, for this agency, yield some valuable material as a basis for a coöperative enterprise, and looking ahead to a long-time relationship with the agency, considered it advisable to attempt the studies. After comparatively brief studies and the usual conference discussion, these boys were regraded in school and given more encouragement by their families, and consequently showed considerable improvement in their behavior and seemed happier. These studies were of more value from the coöperative point of view than they could otherwise have been for they were used as a basis for some interesting discussions between clinic and referring agency on such matters as a child's sensitiveness to continual failure, the defense or flight he is likely to resort to, his need in his own home for a standing as good as that of his brothers, his improvement in behavior when he finds himself achieving something, and thereby winning approval. When this worker next comes to the clinic, an effort will be made to find in her cases other phases of a child's behavior problems and a fresh approach to the treatment of her cases, so that the clinic material will possibly be a matter of progressive interest to her.

Yet another agency likes its workers to carry some intensive cases with the clinic as a sort of study project, and for this organization a more complex type of treatment program is usually planned.

The process of making joint treatment plans between clinic and coöperating agency has certain interesting implications

for the psychiatric worker. Presumably, the first approach to treatment is made in a conference at which there is free discussion of clinic findings and of possible therapeutic measures. At this conference the clinic's attitude and manner of approach to the making of coöperative plans for treatment have a rather far-reaching significance in the matter of agency interrelationships. If the clinic sees certain treatment steps as having possible value, and can mention them as a tentative suggestion rather than as a recommendation, much has been done toward making the enterprise a truly coöperative one. The avoidance of anything that savors of handing out an edict places a wholesome responsibility on the clinic. It implies, for instance, that any plan of action the clinic thinks desirable must have been thoughtfully considered, so that it will be accepted for action, not because it comes weighted with psychiatric prestige, but because it seems to the agency a good suggestion, workable and worth following. This means that the clinic must evolve it in feasible terms, clearly related to the patient's needs, with recognition of the agency's previous work in this family and subject to any modification that may make it more practicable for the agency to carry out. A plan so evolved and acted upon has an interesting bearing upon the matter of responsibility jointly carried by clinic and agency. Any treatment plan accepted by an agency worker, not because it seems interesting and workable, but rather because the clinic recommended it, is probably carried out skeptically and with little understanding, and is nearly always doomed to failure. Its failure involves the prestige of the clinic, which has assumed the responsibility of formulating a recommendation thoroughly approved and understood only by itself. A plan jointly evolved, to which the clinic has contributed suggestions thoughtfully made, is probably carried out with more interest and with sufficient feeling for its possibilities, so that it stands a much better chance of success—a success that is the agency's achievement. There is the possibility, too, that a plan assimilated and acted upon in this way may carry with it some philosophy of approach which may become part of the agency worker's equipment, usable in other cases never brought to the clinic.

The whole question as to the amount and type of respon-

sibility that the clinic should assume in treatment cases jointly carried is one that presents several angles worth considering. If the clinic, tempted by the fascination of a certain coöperative case problem, assumes responsibility for many of the family contacts, and the referring agency thereby loses the major threads of a situation in its own field, the clinic may have placed itself in an unfortunate position. Even in the unlikely event that the treatment is very successful, the coöperative aspect is a failure, for the coöperating agency has been robbed of the most vital and interesting contacts with its own case. If, on the other hand, the outcome is unsuccessful, the pedestal of superior technique on which the clinic has placed itself in taking over the case becomes an uncomfortable one to remain upon.

The question as to the amount of flexibility that it is possible for a child-study clinic to use in its treatment and follow-up of coöperative cases has aspects worth considering. In some communities it has seemed best to have practically an individual policy for each agency in such matters as the amount of attention given the case, the way in which reports are exchanged, the frequency of contact with the agency, and so forth. It has seemed wise to adhere only to the general idea that the clinic should avoid making any agency feel that coöperative treatment is burdensome and impractical, or that an attempt is being made to supervise the agency or to raise its standards. For some organizations an intensive-treatment program on any case, no matter how interesting, is often out of the question because of a heavy case load. Other agencies may be eager to select a few cases on which to develop a different approach, and may wish to work intensively on these. It has seemed best that coöperative work with both types of agency should imply for the clinic not a supervisory interest, but the responsibility of making its suggestions in terms sufficiently workable and worth while to be acted upon by the agency in the course of its usual contacts with the family. One worker from an agency ordinarily unable to do intensive, long-time work brought to the clinic the case of an adolescent boy who was stealing and playing truant. The family was a very large one, its emotional situation endlessly involved, the mother a problem of "nerves" and helplessness, long

known to the agency and not hopefully viewed by the coöperating worker as treatment material. It was out of the question for this worker to explore thoroughly in order to learn what each member of the family meant to the others, much less for her to institute a campaign to adjust them all. The child's responsiveness to the psychiatrist, and some of his vocational interests, formed the basis of a reinterpretation which the worker was able to make to the stepfather concerning the boy, and the stepfather's subsequent interest in the patient quite turned the tide of affairs. This was accomplished in the few and rather brief visits which the worker was able to make in the course of her usual routine. As a result of the clinic's study, an interest in doing more intensive work on some cases does develop on the part of the agency worker, but this increased intensity of effort has been regarded by the clinic as a by-product, not an end in itself.

Coöperative treatment, based on an individualized policy for each agency, has seemed to depend for success chiefly upon personal contacts between clinic and agency, rather than on routine written reports or blanks to be filled out. With some agencies the exchange of written material has been developed so that the clinic receives carbon copies of the agency workers' notes as they are typed in the agency record and sends out copies of treatment interviews held on coöperative cases by clinic staff members. This procedure has been notably satisfactory with such organizations as child-placing agencies and visiting teachers, but it has by no means taken the place of individual contacts with outside workers. These interviews may well be timed by the psychiatric worker on the basis of her knowledge of the agency's situation, and may bring up for discussion such questions as what progress the case is making or what suggestions either the agency or the clinic worker has to add to the plan already under way. A candid review as to what brought results and what did not often constitutes a healthy experience for the clinic in facing some phases of reality, perhaps otherwise neglected, and contact with the agency during the course of coöperative treatment may raise some challenging questions for the clinic. To what degree, for instance, is the clinic able to make workable for others its mental-hygiene concepts? Have the outside worker

and her agency actually been sympathetically understood by the clinic? How is the clinic being viewed by other community organizations?

One phase of coöperative treatment perhaps not often considered by the psychiatric worker is that of the contribution that non-psychiatric agencies make to the clinic, when one works closely and appreciatively with them. For the most part, psychiatric work is so comparatively young that it has much to learn, for instance, from reading the record of a child who has been under close supervision in foster homes for perhaps ten years—what his response has actually been to a period of thoughtful treatment over this length of time. When we have read the long-time record of a good family agency, faced with the absolute necessity of doing something with a most unpromising family and achieving constructive results, we have revised our previously conceived notion as to what constitutes "hopeful material". One acquires wholesome perspective by working closely with some one who sees the family of the problem child, not as a background for the clinic's patient, but as a group whose welfare as a family is a matter for serious concern. Viewed in this way, coöperative work may become a valuable means of enlarging the psychiatric clinic's field of experience.

THE PSYCHIATRIC SOCIAL WORKER AS CONSULTANT IN A SOCIAL AGENCY *

EDITH BAIN

Clinical Assistant in Social Work, Baltimore Clinic, Mental Hygiene Society of Maryland

IN discussing the job of a psychiatric social worker as a consultant on the staff of a social agency, let me state at the outset that I think such a job should be conceived of only as a stop gap, looking toward the time when psychiatric training will be part and parcel of the general case-work training of every social case-worker. But at the present time, when comparatively few social workers are trained in schools of social work and agencies must still do their own training, a psychiatric worker may be an invaluable aid in supplying, in a measure, the mental-hygiene point of view in the case-work of an agency. Any such consultant service should be supplemented by mental-hygiene courses for staff workers, given by a psychiatrist if one is available, and if not by the worker herself. Such a consultant worker should be not only a trained psychiatric worker, but a trained social case-worker as well. This seems to be important for two reasons—first, because the consultant worker herself should be thoroughly familiar with the problems that confront the average case-worker—such problems as heavy case load and relief problems—and second, because of the attitude we still find prevalent among many case-workers toward the psychiatric worker, a defensive attitude, based, perhaps, on a feeling of inferiority.

If we consider for a moment the statistics of two family agencies, we see that a large proportion of the problems of

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these agencies are those in which some form of psychiatric service is indicated. The first are the figures for only one month, the total of behavior and mental problems being 165. These problems included epilepsy, alcoholism, mental difficulty suspected, mental defect, irregular school attendance, juvenile-court problems, juvenile delinquency, immorality, illegitimacy, and other domestic difficulties. The second agency had 445 families, out of a total of from 1,000 to 1,100, that presented similar problems, with the addition of truancy and parent-child problems. In view of the large case load of most social agencies, it would seem impossible to have all cases that present such problems go routinely through the hands of a psychiatric consultant for intensive study and analysis. A conference with the case-worker might suffice in the more obvious mentally diseased and defective cases, the consultant advising and steering the worker to the clinic that would give the most effective service in a particular case. In cases that present more subtle personality difficulties—such as maladjustments between members of a family, school maladjustments, problem children in foster homes, and the like—a careful study of the case by the consultant herself would seem necessary to help the worker, in her investigation, choose the cases that might profit by clinic study and those that she can handle herself.

Some of the best mental-hygiene teaching might be done through assistance in preparing social histories for psychiatric clinics. Such histories are still a bugaboo to many case-workers, and though little of the material that goes into one is not of value to the case-worker herself in the analysis and treatment of the case, if she but sees the significance of it, she still rebels at having to gather what she considers much unnecessary information. Too many histories submitted to clinics contain only factual material, a history of events that have happened in an individual's career, without information regarding the personalities of parents, foster parents, siblings, or whoever may have influenced the development of the particular personality that the individual is at that moment. For example, I recall the history of one girl who had been in ten different boarding homes. There was a careful list of the homes, indicating whether they were boarding or free homes,

the length of the child's stay in each, and a description of the child's behavior in each, but nothing as to the personalities of the foster parents and other boarding children in those homes. Even in one home where the child had remained a year and had given no trouble, there was no indication of the elements that gave her the feeling of security that she had so obviously lacked in any other placement. She was removed from this home because its physical and sanitary standards did not meet the agency's requirements. For obvious reasons, a psychiatric worker who is an integral part of the case-worker's own agency could probably do more in helping her see the value of such material than a worker from the clinic.

There is something to be said on the side of the case-worker who submits a social history to a clinic, and spends a good many hours in getting her client to a clinic, and then receives a report from the clinic giving a diagnosis that may be incomprehensible to her and therefore of no assistance. The clinic, which has an enormous number of patients each day and which may be primarily interested in teaching and therefore in diagnosis, has not the time or perhaps the social-work personnel to give detailed recommendations for treatment. The diagnosis that the child is suffering from a feeling of insecurity or inferiority, the resulting behavior being a compensation, and that he should be placed in an environment that will give him a feeling of security or relieve him of competition, may mean little to the case-worker—whose job it is to interpret this diagnosis in language that the family, foster mother, or school-teacher can understand—unless she herself has enough knowledge of mental hygiene to see all its implications. The function of the consultant here would be to interpret that diagnosis to the worker, to help her in formulating a specific plan of treatment, and to act in an advisory capacity in carrying it out. This would undoubtedly go a long way toward eliminating the feeling that I heard one case-worker express not long ago. When advised to return for further advice to a clinic that had seen her client only a few months before, she remarked that she had received no help the first time and would use her own judgment rather than go back to

the clinic. She had not carried out the clinic's first recommendations for the boy, and when he had again got into difficulty, her reaction was to lay the blame on the clinic.

The case-worker's lack of objectivity and inability to analyze her own mental attitude often stand in the way of her doing a good case-work job. Identifying herself with one member of the family perhaps, or with the foster mother, or with the child, makes it impossible for her to view the situation impartially. A worker brings a sixteen-year-old girl to the clinic for study, a girl in a free home who is stealing. The history contains an account over a page long of the girl's misdeeds and only two and a half lines on her good qualities. The worker is unable to see that the foster mother, who has been deserted by her husband and whose only daughter is married, is depending on this girl for all her emotional satisfaction, and that the girl is rebelling against being treated as if she were still a child. The worker says in conference at the clinic that the foster mother is right, that the girl is "hopeless". How much a psychiatric consultant could do in helping such a worker to a more objective point of view, I don't know, but it would be a part of her educational mental-hygiene job in an agency.

Most agencies at present divide their case loads into A, B, and C cases, or make some such classification to distinguish between the more intensive and the briefer types of service. The case-worker who constantly works under the pressure of a large load is, however, often driven by a feeling that she ought to do something on even those cases which appear to her "hopeless", and she spends mental and physical energy trying to carry out plans that are bound to fail from the very nature of the material with which she is working. One example of this type of case always stands out in my mind because of the many months I labored with it myself. If I had had some knowledge of mental hygiene then, I might have recognized it as what Dr. Preston calls "a socially insuperable situation". A psychiatric consultant who could assist the case-worker to evaluate the material with which she is working might relieve her of much mental distress and free her to put her efforts on the more hopeful material.

However much assistance the case-worker may receive from a psychiatric consultant, when it comes to treatment, so much depends on the ability to recognize emotional issues as they arise in contacts with clients, and to push forward at the opportune moment, that I go back to my first point and repeat that the psychiatric consultant can at best serve only as a substitute for the social case-worker who has psychiatric training as an integral part of her own case-work training.

VARIATIONS IN PSYCHIATRIC SOCIAL WORK IN A STATE SERVICE AGENCY *

CORNELIA D. HOPKINS, M.S.S. (SMITH)
Chief of Social Service, Institute for Juvenile Research, Chicago

THERE has been a great deal of discussion in the past year of the term "generic social worker", and social workers, individually and in groups, have attempted to arrive at satisfactory definitions of the field that the term embraces. The progress that has been made by those who participated in the Milford conference and the well-rounded report that resulted have been of interest to all social workers. With this thoughtfully worked out material at hand in the general field, one is very hesitant to attempt hastily a definition in a narrower field such as that of psychiatric social work. On the other hand, evasion of definition is not very satisfactory when it comes to coöperating with other social agencies. It is chiefly this so-called coöperative field that has forced on the psychiatric social worker the necessity of attempting a crystallization of definition for which the field is hardly prepared. The psychiatric social worker recognizes that the field is not clear cut. It varies with the particular situation of the clinic of which she is a part, and with the social setting of the community. When variations are spoken of, however, there is at the same time an assumption of a constant from which there is variation. Unless some working definition of this constant can be made, experiments in "varying the process" seem a risk that so young a profession can ill afford to undertake.

One way in which this constant factor of psychiatric social work might be defined is in terms of adequacy of service to the mentally sick individual. Adequacy is, of course, an

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absolute. This phrase may be enlarged in terms of the usual hospital or clinic procedure. Adequate service, then, must mean an examination that is based on an accurate, full, and sympathetic description of the early history and career of the patient, together with a picture of the social group from which he comes, and treatment that shall not only be planned with this background in mind, but that shall use all the resources the community has to offer. If this is assumed as the constant factor for psychiatric social work, it becomes clear that variations from this lie in the methods by which the service is accomplished rather than in the objectives of the service itself.

The sorting out of the variables in any one clinic in such a way that adequacy of service to each case is assured is always an extremely complex task. Where the territory of the clinic is an entire state, the variables arising from interagency relationships become an even more tangled mesh for the clinic worker to unwind. In both the Chicago area and in the state, the Illinois Institute for Juvenile Research has been experimenting in coöperative work with social agencies. Two of these experiments have been selected for presentation at this time because they have now been under way long enough to permit of an attempt at evaluation. One of these was tried in the urban, one in the rural territory.

In the city the institute has been working steadily toward the development of a closer relationship between the clinic as a whole and the major agencies of the city, through a group of liaison workers. The general plan has been that a psychiatric social worker who is approved by the clinic is appointed to the staff of the agency as consultant on any psychiatric-social-work problems that arise, and is to be considered for all administrative purposes on the staff of the agency. At the same time this consultant is a part of the professional staff of the clinic. Thus having free access to records, resources, meetings, and group discussions of both organizations, the consultant becomes a part of the larger community mental-hygiene group, planning the trends that future mental-hygiene work shall take, both in relation to the staff organization and for the community as a whole.

It is not, of course, possible to enter into a coöperative scheme of this kind without most careful consideration of the

type of agency and of its individual needs. Often the plan eventually hoped for is better carried out if not put into effect as a whole in the beginning. For example, in one such experiment the agency chose as the worker a member of its own staff. This worker had much theoretical knowledge of psychiatry, was a graduate of a school of social work, and was, of course, familiar with the general progress of her own agency. She had not at the time sufficient experience in the handling of psychiatric cases to enter immediately upon a full program as psychiatric social consultant. She was, therefore, placed directly on the staff of the institute for a period of six months. During this time it was arranged that she supervise only those cases which had been referred to the clinic by her agency. At the end of this term, the close supervision that was given initially was lightened and the worker returned to her own agency. She then resumed case-work, but was considered as a consultant for any mental-hygiene problems that might come up in any of the agency cases.

This liaison service means, not that the consultant worker makes decisions on cases, but that she steers the workers on the cases through the intricacies of the clinic organization, so that they may with the least waste motion get the maximum of professional advice on the problems at hand. She suggests ways of securing observations that are difficult to obtain or histories that for one reason or another have been concealed. She suggests methods by which this material may be made most easily available to the psychiatrist. With these arrangements it has been found that the agency has been able to do a more thorough piece of work on the individual case and has a clearer knowledge of the total mental-hygiene program of the community, and that the whole coöperative work between the agencies is facilitated. These experiments have been simply worked out, and step has led to step so easily that the staff now loses sight of the gap between the time when the clinic social worker carried on the whole work of investigation on agency cases—when the worker on the case did not attend the discussion of her case problem, and the only contact was through a written report.

State clinics probably present one of the most difficult problems of organization for adequate case treatment. The

clinic service is a traveling one. In other words, it is intermittent in any given community. The interval between clinics is a month to six weeks, and the period of visit about a week in length. The institute, therefore, considers it of the utmost importance that the centers of these clinics be in cities in which there is already organized a group of social agencies competent to meet the more usual social problems. It is also essential for the leading agencies to have expressed themselves as willing to undertake whatever treatment may be necessary between the visits of the clinic.

In all of these state clinics, work on cases has been done through the coöperating agencies. It is only with the very active assistance of the community agencies that it has been possible either to serve the large numbers admitted to the clinic, or to understand local situations in the diverse communities well enough to organize treatment.

The knowledge that these local agencies have of their own communities and the type of assistance that each agency is able to offer is material that is of permanent value to the clinic worker. Compiled in large numbers, data thus collected should furnish material of value also to the student of community organization. The institute has, therefore, begun to develop a system of community records, and it is through these records, in addition to those of individual cases, that the work of the community clinic may be viewed as a whole.

As community records are not generally used, this term, as used at the institute, may need elaboration. The record is kept in much the same way as is the record of a case. It contains a statement of the community problem, usually in the form of a request for service. The "investigation" consists of the report of the social worker sent by the clinic to the community to evaluate the local situation. In this section detailed pictures of the historical background of the region, its present social structure, and its social agencies are summed up, and an evaluation of each is made in terms of potential relationship to a clinic program. Impressions and facts gained from conferences with representatives of national organizations who have made field trips to the community are included. The social work carried on in the community is summed up from reviews of annual reports and records. The "running record"

contains a detailed account of the establishment of the clinic and its development in the setting described. All educational and demonstration work that has been attempted is noted. Comments are made on the success or failure of each experiment, and recommendations are made for the future development of the general mental-health program. Records are kept of all communities, both those that were successful in establishing clinics and those that failed. These records, it is hoped, will eventually furnish material that may influence future organization in other communities.

All of this is, however, entirely a discussion of method. It is the machinery by which the service to the patient is accomplished—whether this service is rendered directly by the clinic worker's own efforts or by proxy through another agency, a decision that depends upon the position of the clinic in the community. This decision in turn depends upon the clinic's territory and on its responsibility, both as to function and as to the limit of time permitted. It is only after some very clear-cut definitions on these three points—territory, function, and time allowance—have been made that the decisions as to methodology may also become clear cut.

The confusion so frequently seen in methodology, into which so much thought and planning goes, is probably partly explained by a consideration of the basic training of the psychiatric social worker. In an effort to impress upon the student the importance of personality patterns, it is easy to overstress, and by this overstressing it is easy to send the student out of the school with an idea that these subtleties of personality can be recognized and dealt with only by a worker with exactly the same type of training and experience as that which the student herself has just acquired. She is apt to consider a different type of training, or less training, as a makeshift. This point of view makes a basis for the work of the individual alone upon her own case, but does not tend to fit her to be a part of the whole social structure of the community.

The individual conference on the case has been the most usual method of initiating coöperative work. This means that two or more workers build up a plan on a case in the light of their several previous experiences. The community worker

on this basis learns much from the conferences that she may have with older workers—those who can speak from a background of experience in case-work running into the hundreds of cases. She knows that from the younger worker she can gain less. This must always be so to a certain extent, for with long experience comes a seasoned judgment that no amount of education can produce. There is a question, however, as to whether the gap needs to be as great as it is between the newly trained worker and the one who is seasoned. At present the teaching of psychiatric social work seems to be chiefly the exposition of an art. As an art it must be recognized that, while certain basic techniques may be taught, the skillful use of these techniques is highly individual. It has been the hope of social workers that this basic technique may be made more readily available through the building up of a body of case material similar to that on hand in the older fields of medicine and law. The younger worker can turn to this body of knowledge to supplement her own new knowledge with that of the procedures of the past. A program within individual offices that would aim at making available to case-workers indexed excerpts from case records would be feasible, and would fill a very definite need. If these records contain not only the techniques of case-work on the individual and on the community, but also the agency methodology, they might do much toward clarifying our knowledge of what it is possible for two agencies to accomplish working together, and what each must work out alone.

NEW TRENDS IN PSYCHIATRIC SOCIAL TREATMENT IN THE FAMILY AGENCY *

BEATRICE Z. LEVEY
District Superintendent, United Charities, Chicago

THERE has been a steady growth in the direction of the psychiatric point of view in family case-work. Not so long ago, it was possible to find in case records treatment letters such as the following:

> My dear Mr. Smith:
>
> We have recently been informed that you are drinking and abusing your wife and children. This state of affairs cannot go on and if you continue this kind of conduct, you will undoubtedly be arrested and sent to the House of Correction.
>
> We should like to have you come to this office and talk this matter over with us before we take any action.

Obviously, this is not an example of what we call the psychiatric point of view in social case-work.

Briefly, what is the psychiatric point of view? In a large sense it began, before it was called psychiatric, with "that emergent truth" which Dean Pound has called "the most important change of the century . . . the transference of the sense of value from property to humanity". In a working sense, it is a search for the genesis of behavior in a manner that more closely approaches the scientific method than the moralistic. Family case-work has for many years emphasized the "What shall I do?" refrain, at the expense of the "Why did this happen?" motif. "Why did this happen?" is the ever-recurring phrase in psychiatric social work.

What, then, should be the attitude of a psychiatric social worker in a family agency? Family case-work, because of its

* Read as part of a symposium on "Psychiatric Social Work in Relation to the Work of Social Agencies" at the annual meeting of the American Association of Psychiatric Social Workers, Memphis, Tennessee, May 2–7, 1928. For the other papers in the symposium, see pages 108–17, 118–22, 123–28 of the present number of MENTAL HYGIENE.

long and successful history, can be looked upon as a convention. John Lowes, in his *Convention and Revolt in Poetry,* points out that there are three determining attitudes toward conventions: we may accept them and passively conform; we may smash them and go on; or we may keep and mold them. To accept and passively conform to conventions, even if the convention be that of family case-work, leaves no place for the psychiatric social worker. To smash what we choose to call conventional social work leaves us without the impregnable foundation that Miss Richmond has built for us in her *Social Diagnosis.* To keep and mold is, then, the attitude that the psychiatric social worker has toward conventional family case-work. In keeping and molding family case-work, the psychiatric social worker is able to create new values in social work. From this point of view, psychiatric social work may be defined as transmuted family case-work.

The creation of new values is necessarily a slow process. In one of the district offices of the Chicago United Charities, an attempt is being made to stimulate the growth of psychiatric values in family case-work through staff discussions, case conferences, suggested reading, and coöperative work with psychiatric clinics.

Staff discussions provide an admirable medium for disturbing the traditional beliefs of the case-worker. In the staff conference, the drinking husband loses the label of reprobate and emerges as an individual to be studied. In order to study him, it has been found necessary to include in the usual investigation those items of history that are to be found in the psychiatric-social-history outlines now in general use in the clinics. Here family case-work and psychiatric social work have come together in the working out of a more scientific method of investigation. This method demands more thought and work, but it saves time in the end, because in the process of gathering the required information, the worker discovers that she is outlining the future treatment of the case.

In a district office whose case load averages four hundred a month, it is impossible to have long individual conferences with the workers on each case. The bulk of the cases are supervised indirectly through two assistants, chosen because of their knowledge of family case-work and their interest in

the psychiatric point of view. This plan of indirect supervision of the major part of the case load makes possible direct and intensive supervision of a limited number of selected cases. Here an attempt is made to get behind the psychiatric vocabulary (which usually precedes the psychiatric point of view in social work) to the mechanisms of which the vocabulary is a symbol. In this connection, well-chosen reading assignments in psychiatric literature are an aid in attuning the worker to the dominant motif in psychiatric social work, which we have designated as "Why did this happen?"

The work with the Illinois Institute for Juvenile Research is an example of coöperative work with psychiatric clinics. During the last two years the Institute for Juvenile Research has been making an effort to coördinate its work more closely with that of the Chicago United Charities. Practically, how is such a coördination being effected? The family case-worker is not only encouraged to attend the staff conference on the case which she brings to this clinic for examination, but she is urged to participate in the discussion of the case. She is beginning to view psychiatric recommendations, not as edicts or as magical formulæ carrying with them instantaneous cures, but as tentative steps in the investigation and treatment of her cases. In addition to this, the United Charities released one worker for three months to the Institute for Juvenile Research and subsidized her salary. A plan is now being considered whereby workers from the United Charities can come to the institute for two-day periods. Another plan is being formulated in which workers from the institute will carry, in coöperation with the United Charities, a selected number of cases known to both agencies.

The coördination of psychiatric social work and family case-work is important when one considers the general direction of social work. The psychiatric point of view enables us to see the latent possibilities in social work and, through the adding of new values, it changes or transmutes family case-work. Psychiatric social work apart from family case-work and family case-work apart from psychiatric social work lack the strength for possible purposive direction that they possess in combination.

EXPECTATION OF MENTAL DISEASE

HORATIO M. POLLOCK AND BENJAMIN MALZBERG
New York State Department of Mental Hygiene

SOME years ago Dr. Thomas W. Salmon raised the question of the expectation of mental disease by asking what proportion of the population become patients in hospitals for mental disease in the course of a generation. He attempted to find an answer by comparing deaths in a single year in New York State in hospitals for mental disease with those in the general population. He found that in a given year 1–22 of the deaths reported to the New York State Health Department occurred in hospitals for mental patients. Comparing deaths in such hospitals with admissions, he found that the latter were approximately twice as great as the former. He concluded from these data that about one out of every ten or eleven persons became mentally ill in the course of a generation. The estimate was made from data drawn from several generations and proved much too high.

A preliminary combined mortality and mental-disease table prepared at the time of Dr. Salmon's inquiry in the statistical bureau of the New York State Hospital Commission from crude data gave the proportion of those becoming mentally ill in the course of a generation as approximately 1 in 25.

The study herewith presented is an attempt to show more definitely the expectation of mental disease in New York State, not only at birth, but at every age of life. The life-table method of analysis has been used and the data have been segregated by sex and nativity. So far as is known, this is the first attempt to produce standard, combined life and mental-disease tables.

The data with respect to mental disease have been derived from individual statistical schedules of first admissions prepared in the state hospitals and licensed institutions for

mental disease in New York State, and sent regularly to the statistical bureau of the department of mental hygiene.

Cases of mental disease too mild to require admission to a hospital are not considered in this study.

In order to secure an adequate number of cases for detailed analysis, the first admissions of 1919, 1920, and 1921 were taken, comprising a total of 21,997 cases. These were subdivided as follows: native males, 6,362; native females, 5,697; foreign-born males, 5,373; foreign-born females, 4,565. Each nativity group was classified by age and sex and the average annual number of first admissions of each class was computed.

Corresponding data for the general population of the state of New York were taken from the United States Census of 1920 and were adjusted to read as of July 1, 1920. As is always to be expected in such data, there was great irregularity in the age distribution of the patients and of the general population and it was consequently necessary to smooth the data before beginning the analysis. Both the hospital admissions and the general population were grouped into quinquennial age periods. The subsequent smoothing and interpolations were made by applying the method of osculatory interpolation as illustrated by John Burns, F.I.A., in the appendix to his *Vital Statistics Explained*. From the smoothed data the probability of mental disease at each age was obtained by the usual formula—that is, $s_x = 2i_x \div (2l_x + i_x)$, in which s_x represents the probability of mental disease at age x, i_x the number becoming mental patients during the xth year, and l_x the total population at the same age. Good results were obtained for almost the entire range of the table. There were, however, so few cases under thirteen years of age that it was necessary to assume that the incidence of mental disease began at that age. This is, in fact, a safe assumption, as data carefully gathered for twenty years show that there are very few first admissions under fifteen years of age, the exceptions being a small number of children suffering from epidemic encephalitis. There was corresponding difficulty at the other end of the table, as there were too few cases past ninety years of age to yield adequate rates. Consequently, the data, where necessary, were completed by extrapolating

the rates graphically on the assumption of a parabolic distribution. As will be shown in the tables, there are so few mentally ill individuals to be expected at these ages that it would require an error in the rates of mental disease amounting to an exceedingly high order to cause any significant error in the resulting probabilities.

As noted above, the rates of mental disease were computed for individual years, for each sex, under the categories of native and foreign born. The nativity groups were then combined, and two additional tables were constructed, representing total males and females in the state of New York.

In carrying out the analysis, it was necessary to make use of life tables in conjunction with the probabilities of mental disease. Because of the fact that no complete life tables are available that include exactly the same elements utilized in the present study, it was necessary to make certain assumptions. There is no complete life table for the state of New York for 1920 for all males or for all females. It was, therefore, necessary to use tables for the United States Registration States, and these were kindly furnished by Dr. Louis I. Dublin, statistician of the Metropolitan Life Insurance Company, in whose statistical bureau the abridged Foudray 1920 table was completed for all intervening years. In the remaining cases it was possible to use data for the state of New York. These consist of life tables prepared in the Division of Vital Statistics in the New York State Department of Health for the following groups: native males, native females, foreign-born males, and foreign-born females. These tables, however, all begin with the age of twenty. This is due to the fact that in the foreign-born groups, there are too few individuals at the earlier ages to permit the calculation of accurate mortality rates. In order to make all the life tables directly comparable, they were begun at age twenty. Since, for the purpose of the present study, mortality rates were needed for each year, they were supplied from birth to the twentieth year on the following assumptions: in the case of the native group, it was assumed that the ratio of the mortality rates at each year under twenty in 1920 to the corresponding rates in 1910, as given by Glover, was equal to the

ratio of the mortality rates in 1920 at each age under twenty, as given by Dr. Dublin for total whites in the United States Registration area, to the rates in the United States Registration area in 1910, as given by Glover. In the case of the foreign-born females, such assumptions gave discordant results, and it was thought better, therefore, to apply the Dublin values for total white females for ages zero to twenty. Similarly in the case of the foreign-born males, the mortality rates from birth through the fifth year were assumed to be the same as given by Dublin for the native males. It is true that this introduces an element of uncertainty, but the resulting error, if any, will be a slight underestimate rather than an overestimate, as the mortality rates for the foreign-born actually exceed those for the native population. However, the final error cannot be great because of the fact that the essential data relating to the number of the mentally ill do not begin until age thirteen, and the subsequent rates up to age twenty, where the rates of mortality and mental disease refer to the same nativity groups, are too low to cause any significant statistical errors.

The subsequent analysis was made in the following manner: The total population alive and sane at the exact age x was multiplied by the corresponding value of s_x to obtain i_x, the number becoming mentally ill in that age interval. If i_x is then deducted from l_x, the remainder will represent the number alive at age x who did not become mentally ill during that year. This new total, multiplied by q_x, the life-table rate of mortality, gives the number of the latter group who will die in the xth year. Deducting these deaths gives the population alive and same at exact age $x + 1$. This procedure is followed for each age until the entire population has disappeared. The method may be more clearly understood by referring to Table 3, which shows the probability of mental disease among total males in the state of New York in 1920. This begins with a population of 100,000 at birth. It will be noticed that there are no mental cases until the thirteenth year is attained. Consequently, up to that year, each yearly population need be multiplied only by the rate of mortality and the corresponding deduction made to obtain the population at the succeed-

ing age level which has remained both alive and mentally well. At age thirteen, there is of the original group a total of 86,388 living individuals. Multiplying this by 5.6, the rate of mental disease per 100,000 population at age thirteen, we get an expectation of 5 cases of mental disease. Deducting these from 86,388, we obtain the population alive at exact age thirteen who did not become mentally diseased in the thirteenth year. Multiplying this number, 86,383, by the rate of mortality per thousand, 2.4, gives the expected number of deaths, 207, which, when deducted from 86,383, gives 86,176 as the number of white males alive and sane at exact age fourteen out of a population of 100,000 at birth. This procedure thus gives the number becoming mentally ill in each age interval until the entire population has disappeared.

Beginning, then, with the last year to provide any cases of mental disease, proceed to add cumulatively back to birth. The cumulative total at each age tells how many individuals out of those alive and sane at that age became mentally diseased before death. Dividing the cumulative total at any age by the population alive and sane at that age gives the expectation of mental disease at such age. Each expectation was reduced to the basis of 100. Thus, in the case of the total males, the expectation at birth is that 4.7 per 100 will become mentally diseased before death.

Table 1 is a summarized statement of the expectations of mental disease in the several groups, beginning with birth. It should be noted that the expectation at birth of the males exceeds that of the females. In the total groups, the expectations at birth are 4.7 per 100 for males and 4.4 for females. These increase to a maximum at age fifteen of 5.5 for males and 5.1 for females. In succeeding years there is a continuous decrease. It should be noted that, the cumulative total of the mentally ill being the same from birth to the thirteenth year, the increased expectancy up to the latter year can be entirely accounted for by the decreasing life-table function l_x, which furnishes the denominator in the expression for the expectation of mental disease.

If now the total group be analyzed according to nativity,

TABLE 1. NUMBER BECOMING MENTALLY ILL DURING REMAINDER OF LIFE OF 100 ALIVE AND SANE AT SPECIFIED AGE, BY NATIVITY AND SEX

Exact age in years	*Total*		*Native*		*Foreign-born*	
	Male	Female	Male	Female	Male	Female
0	4.7	4.4	4.3	4.0	5.4	5.2
5	5.4	5.0	4.9	4.4	6.1	5.8
10	5.4	5.1	5.0	4.4	6.2	5.8
15	5.5	5.1	5.0	4.5	6.2	5.9
20	5.3	5.0	4.9	4.4	5.8	5.7
25	5.0	4.9	4.6	4.3	5.3	5.4
30	4.7	4.6	4.3	4.1	4.9	5.1
35	4.4	4.4	4.0	3.8	4.4	4.7
40	4.0	4.1	3.7	3.5	4.0	4.3
45	3.7	3.8	3.4	3.2	3.6	4.0
50	3.4	3.4	3.1	2.9	3.3	3.6
55	3.1	3.1	2.8	2.6	3.0	3.3
60	2.8	2.9	2.6	2.4	2.8	3.1
65	2.6	2.6	2.4	2.2	2.5	2.9
70	2.3	2.4	2.1	2.0	2.3	2.7
75	2.0	2.2	1.8	1.9	2.1	2.4
80	1.8	2.0	1.5	1.7	1.9	2.2
85	1.5	1.6	1.2	1.4	1.7	1.9
90	1.2	1.3	1.0	1.2	1.4	1.7
95	1.0	1.0	0.7	1.0	0.9	1.4

it is seen that the expectation of mental disease among the foreign born is higher than that among the native groups at every quinquennium, the males again exceeding the females. The expectations at birth for males are 4.3 and 5.4 per 100 for native and foreign born respectively; for females, they are 4.0 and 5.2 respectively. In each nativity group there is a similar increase in expectation of mental disease up to approximately the fourteenth year and then an uninterrupted decrease. The expectation reaches a maximum of 6.2 per 100 in the foreign-born male group. It should be noted that in each case the expectation among females in the advanced age groups exceeds that of the males. In the case of the total male, total female, native male, and native female groups the higher expectation for females does not occur until the seventy-fifth quinquennium; but in the case of the foreign born, the expectation for females is higher from the twenty-fifth quinquennium on. These results may be accounted for both by the higher rates of mental disease among females at the older ages and also by their greater longevity.

TABLE 2. SUMMARY OF AVERAGE ANNUAL RATES OF FIRST ADMISSIONS PER 100,000 GENERAL POPULATION TO ALL HOSPITALS FOR MENTAL DISEASES IN NEW YORK, 1919–1921 INCLUSIVE, BY AGE, NATIVITY, AND SEX

Exact age in years	*Total*		*Native*		*Foreign-born*	
	Male	Female	Male	Female	Male	Female
0	....	....	....	....	....	....
5	....	....	....	....	....	....
10	....	....	....	....	....	....
15	34.8	24.4	29.2	18.2	86.1	51.7
20	78.1	47.5	68.4	42.2	131.8	71.3
25	94.6	70.0	83.4	61.9	129.2	94.1
30	101.6	86.6	91.4	76.9	123.4	106.8
35	106.6	91.4	98.1	85.1	124.0	107.5
40	107.7	94.0	102.1	92.5	123.4	108.5
45	102.2	99.8	96.7	94.3	114.2	117.1
50	98.6	105.6	94.0	95.7	108.9	122.0
55	106.4	108.4	101.2	98.2	116.0	119.9
60	122.1	110.5	117.1	101.2	131.8	124.8
65	148.5	134.7	142.7	112.3	160.3	162.7
70	190.1	166.7	183.9	136.0	203.4	217.0
75	219.7	213.8	215.0	180.2	239.0	268.9
80	260.5	279.9	245.1	234.2	291.0	353.4
85	314.0	324.5	275.0	285.5	370.5	414.0
90	345.0	347.0	306.1	343.0	433.0	482.0
95	388.5	412.5	337.0	427.0	511.0	598.0

Table 2 summarizes the rates of mental disease. In the two groups, total and native, there is a gradual increase in rates of mental disease from adolescence to old age, with the exception of a slight decrease in the rates for males in the fourth and fifth decades of life. The rates for the foreign-born males do not show the same regularity. This results in all probability from the high rate of dementia præcox among the younger foreign-born males. After fifty years of age, however, a steady increase is clearly evidenced. The rates for foreign-born females are lower than those for foreign-born males up to the fortieth quinquennium, but thereafter the rates for males are the lower. In the native group no such marked differences are found in the rates for the two sexes in the early ages. The explanation may, perhaps, be found in the greater difficulty that the older foreign-born female finds in adjusting herself to different patterns of behavior and culture.

Complete data for each year of life are shown in Tables 3–8. Charts I and II (pages 139–40) show comparative curves of

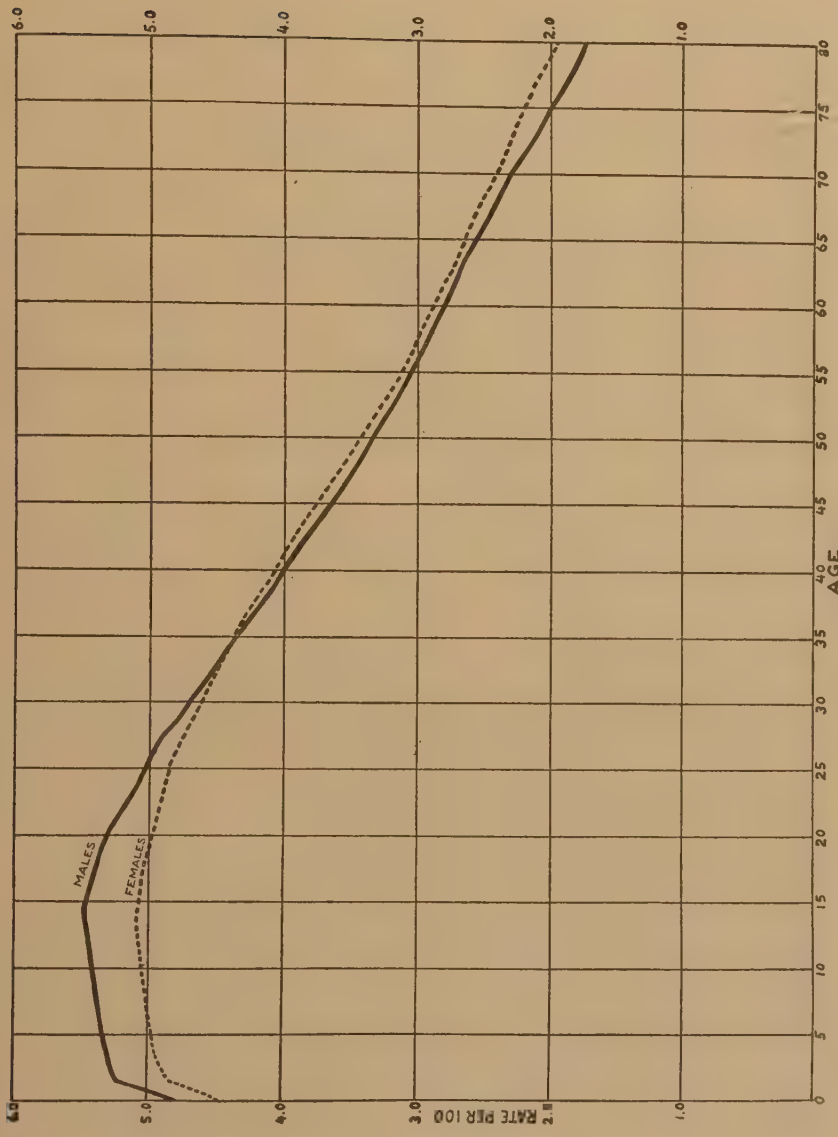

Chart I. Expectation of mental disease among males and females in New York State per 100 alive and sane at specified ages.

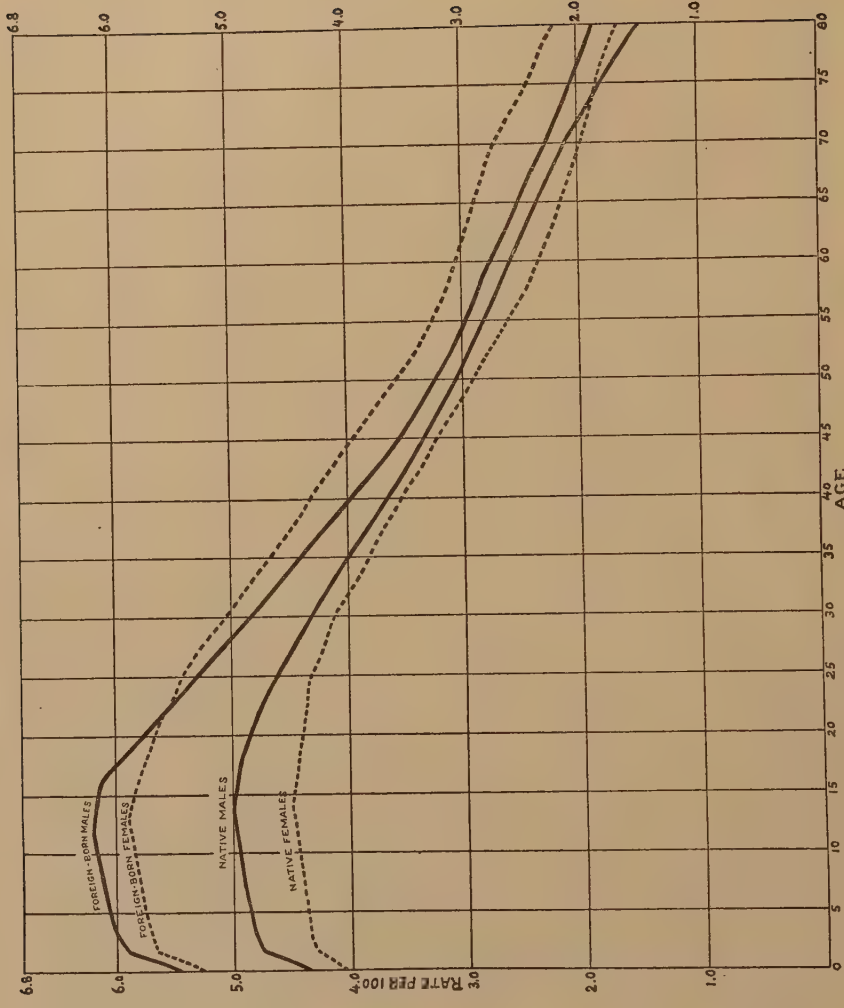

Chart II. Expectation of mental disease in New York State per 100 alive and sane of same nativity and sex at specified ages.

expectation of mental disease among the several age and sex groups covering the entire life span. Chart I gives a graphic comparison of the rates of expectation of mental disease among males and females. The rates among males are the higher up to age thirty-four. From age thirty-four to age sixty-five the rates for the two sexes are nearly equal, those of the females being slightly in excess. For ages from sixty-five years upwards the higher rate of the females is more marked.

Chart II compares by sex the expectation of mental disease throughout life among the native and foreign born. The expectation of mental disease of the native males, beginning with 4.3 per 100 at birth, rises to a maximum of 5.0 from the tenth to the seventeenth year and then decreases regularly to the end of the life span. The expectation of the native females, beginning with 4.0 per 100 at birth rises to a maximum of 4.5 from the twelfth to the sixteenth year, and decreases regularly thereafter. The expectation of the males continues in excess until the seventy-fourth year. Thereafter, as noted above, the expectation of the females is the greater.

In the case of the foreign born, the expectation of mental disease of the males increases from 5.4 per 100 at birth to a maximum of 6.2 from the ninth to the fifteenth year and then decreases. The expectation of the foreign-born females is lower than that of the males, beginning with 5.2 per 100 at birth and rising to a maximum of 5.9 from the eleventh to the fifteenth year. Beyond the twenty-fifth year the expectation of the females exceeds that of the males.

Charts III and IV (pages 142–43) show rates of incidence of serious mental disease per 100,000 of population of the same age, sex, and nativity. As previously mentioned, the rates are based on the average annual first admissions to all institutions for mental disease in New York State during the fiscal years ended June 30, 1919, 1920, and 1921. The population data were derived from the Federal Census of New York State of 1920. The data from both sources were smoothed before the rates were computed.

Chart III compares rates of mental disease among males

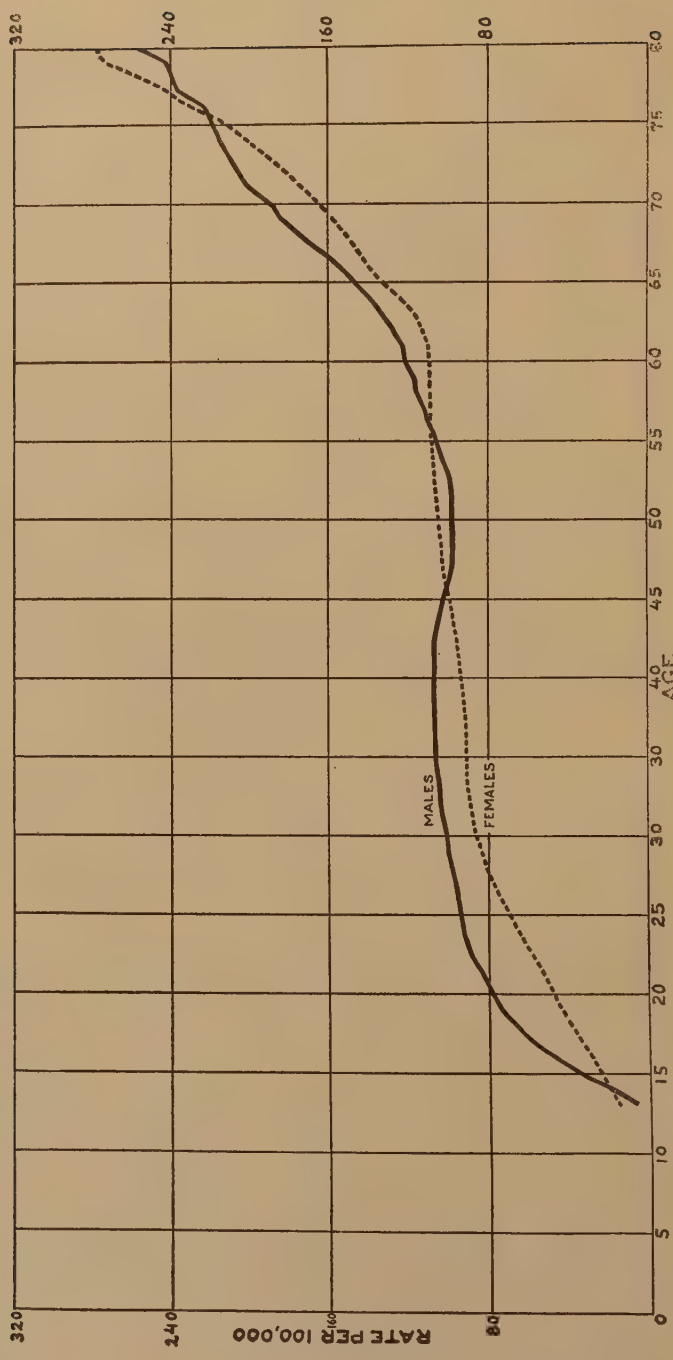

Chart III. Rates of mental disease in New York State per 100,000 population of sane age and sex.

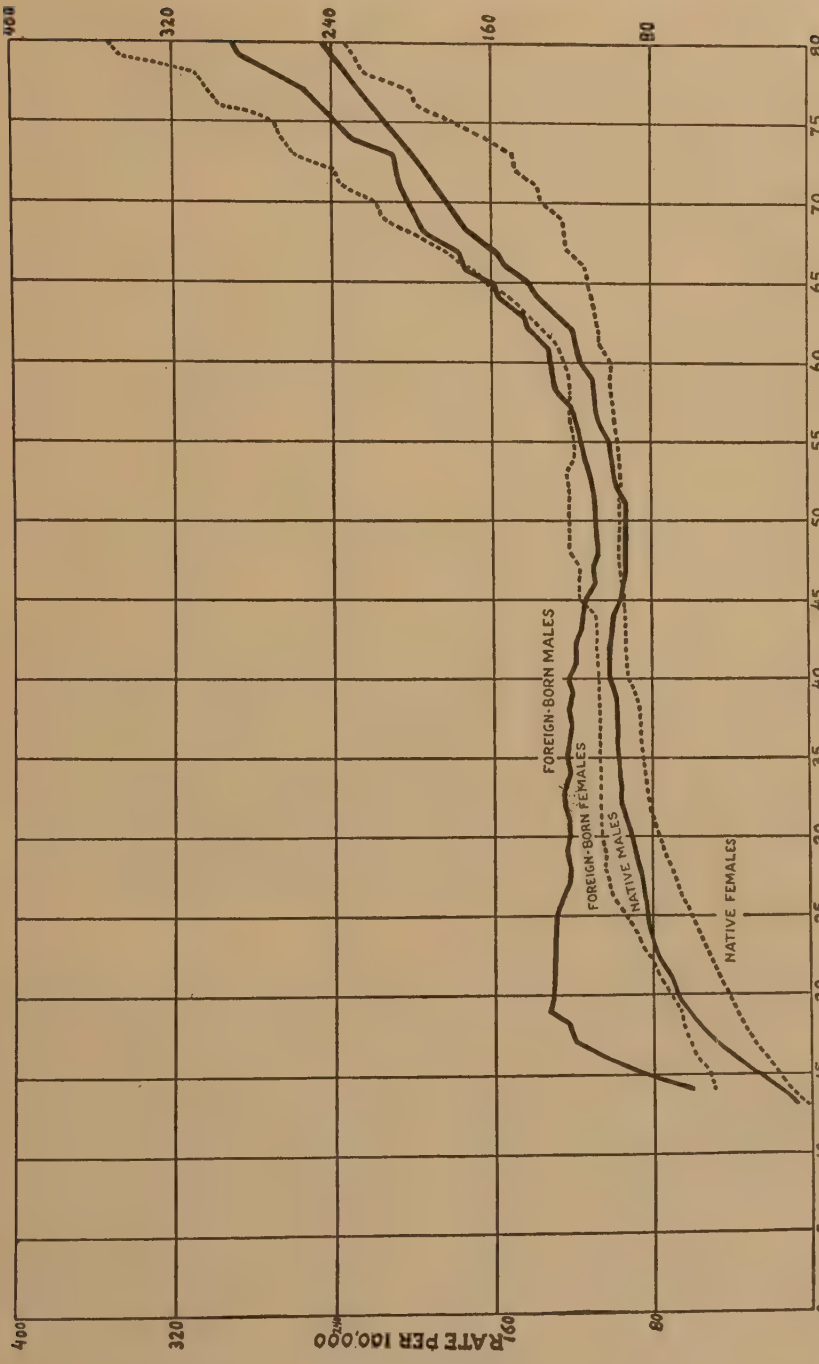

Chart IV. Rates of mental disease in New York State per 100,000 population of same sex, nativity and age.

and females from thirteen to eighty years of age. It will be noted that the males have the higher rates from age fourteen to age forty-five and from age fifty-six to age seventy-six. The rates of both sexes increase with advancing age, excepting a slight reduction in the rates of the males from age forty-two to age fifty-six.

Chart IV compares rates of mental disease by sex among the native and foreign-born population of the state. The rates of the native group are lower than those of the foreign-born group at every age. In both nativity groups, the males have higher rates than the females except during the involutional and advanced age periods. These comparative rates are relatively similar to those shown by the Federal Census report, *Patients in Hospitals for Mental Disease, 1923* (page 32), although the rates for New York are higher than those shown for the country as a whole.

The higher rates of expectation and the higher rates of incidence of mental disease among the foreign born raise the question of their real significance. Do these indicate differences of a biological or a social order? It has been asserted that the higher rates of mental disease among foreigners indicate their racial inferiority as compared with the native born. Such a conclusion should not be drawn from these data. Such higher rates are more probably due to environmental stresses, such as are incidental to the struggle for existence in a new land.

The data of this study emphasize the seriousness of the problem of mental disease. It appears that approximately 4.5 per cent of the persons born in the state of New York may, under existing conditions, be expected to succumb to mental disease of one form or another, and become patients in hospitals for mental disease. In other words, on the average, approximately 1 person out of 22 becomes a patient in a hospital for mental disease during the life-time of a generation. In the several groups shown in the tables, the ratios of those becoming patients to the whole population group are as follows: All males, 1 to 21.3; all females, 1 to 22.7; native males, 1 to 23.3; native females, 1 to 25; foreign-born males, 1 to 18.5; foreign-born females, 1 to 19.2.

From the data presented in the tables similar ratios may be computed for all of the groups at any age of life. Given the age and nativity composition of any group of persons, the proportion that will probably develop serious mental disease may be determined by applying the appropriate expectation rates as given in the tables. The following tabulation furnishes simple illustrations:

PROBABLE NUMBER AMONG CERTAIN SOCIAL GROUPS WHO WILL DEVELOP SERIOUS MENTAL DISEASE AND BECOME PATIENTS IN A HOSPITAL FOR MENTAL DISEASE *

Among 117,000 male children born in New York State in 1927	5,000
Among 111,000 female children born in New York State in 1927	4,400
Among 1,030,000 boys in public schools of New York State in 1927	51,500
Among 990,000 girls in public schools in New York State in 1927	44,000
Among 194,000 male immigrants to the United States in year ended June 30, 1927	10,000
Among 141,000 female immigrants to the United States in year ended June 30, 1927	7,300
Among 3,500,000 World War veterans with average age of 35 years	154,000

In presenting these results we do not desire to leave the impression that mental disease is a fatalistic matter—that it is as certain as old age or death. Under present conditions, however, mental disease occurs among the general population with striking regularity, and it seems probable that the rate of incidence will not greatly change until the principles of mental hygiene are better known and more widely adopted.

* Round numbers are used as most of the data given are approximations.

TABLE 3. EXPECTATION OF MENTAL DISEASE AMONG MALES IN NEW YORK STATE, 1920

Age interval, years	Of 100,000 persons born alive		Rate of mental disease per 100,000	Rate of mortality per 1,000	Expectation of mental disease
Period of lifetime between two exact ages	Number alive and sane at beginning of age interval	Number becoming mentally ill in age interval	Number becoming mentally ill during age interval among 100,000 alive and sane at beginning of age interval	Number dying in age interval per 1,000 alive at beginning of interval and remaining sane during interval	Number becoming mentally ill during remainder of life of 100 alive and sane at beginning of age interval
x to $x+1$	l_x	i_x	100,000 s_x	1,000 q_x	$t_x = \frac{\sum_{x}^{100} i_x}{l_x}$
0–1	100,000	...	...	84.3	4.7
1–2	91,570	...	...	17.6	5.2
2–3	89,958	...	...	8.5	5.3
3–4	89,193	...	...	5.9	5.3
4–5	88,667	...	...	4.6	5.3
5–6	88,259	...	...	3.9	5.4
6–7	87,915	...	...	3.4	5.4
7–8	87,616	...	...	3.0	5.4
8–9	87,353	...	...	2.5	5.4
9–10	87,135	...	...	2.2	5.4
10–11	86,943	...	...	2.1	5.4
11–12	86,760	...	...	2.1	5.4
12–13	86,578	...	...	2.2	5.4
13–14	86,388	5	5.6	2.4	5.4
14–15	86,176	17	19.3	2.7	5.4
15–16	85,943	30	34.8	3.2	5.4
16–17	85,638	41	47.3	3.6	5.4
17–18	85,289	50	58.7	3.9	5.4
18–19	84,907	56	66.5	4.2	5.4
19–20	84,495	63	74.2	4.4	5.4
20–21	84,060	66	78.1	4.6	5.3
21–22	83,608	69	82.7	4.8	5.3
22–23	83,138	73	87.8	5.0	5.2
23–24	82,650	75	91.0	5.1	5.1
24–25	82,154	76	93.0	5.3	5.1
25–26	81,643	77	94.6	5.4	5.0
26–27	81,126	77	95.4	5.6	5.0
27–28	80,595	78	96.9	5.8	4.9
28–29	80,050	79	98.3	6.0	4.8
29–30	79,491	80	100.2	6.2	4.8
30–31	78,919	80	101.6	6.5	4.7
31–32	78,327	81	103.3	6.7	4.6
32–33	77,722	81	104.3	6.9	4.6
33–34	77,105	82	105.8	7.0	4.5
34–35	76,484	81	106.0	7.2	4.4
35–36	75,853	81	106.6	7.3	4.4

TABLE 3. EXPECTATION OF MENTAL DISEASE AMONG MALES IN NEW YORK STATE, 1920—(*Continued*).

Age interval, years	Of 100,000 persons born alive		Rate of mental disease per 100,000	Rate of mortality per 1,000	Expectation of mental disease
Period of lifetime between two exact ages	Number alive and sane at beginning of age interval	Number becoming mentally ill in age interval	Number becoming mentally ill during age interval among 100,000 alive and sane at beginning of age interval	Number dying in age interval per 1,000 alive at beginning of interval and remaining sane during interval	Number becoming mentally ill during remainder of life of 100 alive and sane at beginning of age interval
x to $x+1$	l_x	i_x	100,000 s_x	1,000 q_x	$t_x = \frac{\sum_{x}^{100} i_x}{l_x}$
36–37	75,219	81	107.2	7.4	4.3
37–38	74,582	80	107.3	7.6	4.2
38–39	73,936	80	107.6	7.8	4.1
39–40	73,280	79	108.0	8.0	4.1
40–41	72,614	78	107.7	8.2	4.0
41–42	71,941	77	107.5	8.4	3.9
42–43	71,260	77	107.4	8.7	3.9
43–44	70,564	75	106.1	8.9	3.8
44–45	69,862	73	104.9	9.2	3.7
45–46	69,147	71	102.2	9.5	3.7
46–47	68,420	69	101.0	9.9	3.6
47–48	67,674	67	99.7	10.4	3.5
48–49	66,904	66	99.0	10.9	3.4
49–50	66,109	65	98.4	11.5	3.4
50–51	65,284	64	98.6	12.2	3.4
51–52	64,424	64	99.0	12.9	3.3
52–53	63,530	63	99.6	13.8	3.2
53–54	62,591	63	100.6	14.9	3.2
54–55	61,596	64	104.1	16.1	3.1
55–56	60,541	64	106.4	17.4	3.1
56–57	59,425	65	110.2	18.8	3.0
57–58	58,244	65	112.1	20.3	3.0
58–59	56,998	66	116.2	21.7	2.9
59–60	55,697	66	117.8	23.1	2.9
60–61	54,346	66	122.1	24.6	2.8
61–62	52,945	65	123.7	26.3	2.8
62–63	51,489	66	128.7	28.4	2.7
63–64	49,963	67	134.5	30.7	2.7
64–65	48,364	68	141.1	33.4	2.7
65–66	46,683	69	148.5	36.4	2.6
66–67	44,917	70	156.7	39.6	2.5
67–68	43,071	71	165.5	43.1	2.5
68–69	41,147	71	174.9	46.9	2.4
69–70	39,149	73	185.2	51.1	2.4
70–71	37,079	70	190.1	55.5	2.3
71–72	34,955	71	201.9	60.3	2.3

TABLE 3. EXPECTATION OF MENTAL DISEASE AMONG MALES IN NEW YORK STATE, 1920—(*Continued*).

Age interval, years	Of 100,000 persons born alive		Rate of mental disease per 100,000	Rate of mortality per 1,000	Expectation of mental disease
Period of lifetime between two exact ages	Number alive and sane at beginning of age interval	Number becoming mentally ill in age interval	Number becoming mentally ill during age interval among 100,000 alive and sane at beginning of age interval	Number dying in age interval per 1,000 alive at beginning of interval and remaining sane during interval	Number becoming mentally ill during remainder of life of 100 alive and sane at beginning of age interval
x to $x + \overline{x}$	l_x	i_x	100,000 s_x	1,000 q_x	$t_x = \frac{\sum_{x}^{100} i_x}{l_x}$
72–73	32,780	68	207.3	65.4	2.2
73–74	30,573	65	212.2	70.8	2.1
74–75	28,348	61	215.9	76.4	2.1
75–76	26,126	57	219.7	82.4	2.0
76–77	23,921	53	222.3	89.0	2.0
77–78	21,744	52	237.4	96.4	1.9
78–79	19,601	47	240.1	104.8	1.8
79–80	17,505	42	241.6	114.2	1.8
80–81	15,469	40	260.5	124.4	1.8
81–82	13,510	38	282.6	135.2	1.7
82–83	11,651	36	307.5	146.0	1.7
83–84	9,919	31	309.1	156.8	1.6
84–85	8,334	26	311.5	167.8	1.5
85–86	6,914	22	314.0	179.3	1.5
86–87	5,656	18	316.2	191.2	1.4
87–88	4,560	15	318.5	204.0	1.4
88–89	3,618	12	327.5	217.8	1.3
89–90	2,821	9	336.0	232.6	1.2
90–91	2,158	7	345.0	248.2	1.2
91–92	1,617	6	353.6	264.0	1.2
92–93	1,186	4	362.5	279.7	1.1
93–94	851	3	371.0	294.6	1.1
94–95	598	2	379.5	308.7	1.0
95–96	412	2	388.5	323.0	1.0
96–97	278	1	397.0	338.5	0.7
97–98	183	1	406.0	356.5	0.5
98–99	117	...	414.5	377.5	..
99–100	73	...	....	401.2	..
100–101	44	...	....	427.1	..
101–102	25	...	....	454.8	..
102–103	14	...	....	483.7	..
103–104	7	...	....	....	..
104–105	4	...	....	....	..
105–106	1	...	....	....	..
106–107	1	...	....	....	..
107–108	....	...	....	....	..

TABLE 4. EXPECTATION OF MENTAL DISEASE AMONG FEMALES IN NEW YORK STATE, 1920

Age interval, years	Of 100,000 persons born alive		Rate of mental disease per 100,000	Rate of mortality per 1,000	Expectation of mental disease
Period of lifetime between two exact ages	Number alive and sane at beginning of age interval	Number becoming mentally ill in age interval	Number becoming mentally ill during age interval among 100,000 alive and sane at beginning of age interval	Number dying in age interval per 1,000 alive at beginning of interval and remaining sane during interval	Number becoming mentally ill during remainder of life of 100 alive and sane at beginning of age interval
x to $x+1$	l_x	i_x	100,000 s_x	1,000 q_x	$e_x = \frac{\sum_{x}^{100} i_x}{l_x}$
0–1	100,000	...	....	67.3	4.4
1–2	93,270	...	....	15.8	4.8
2–3	91,796	...	....	7.7	4.9
3–4	91,089	...	....	5.6	4.9
4–5	90,579	...	....	4.1	5.0
5–6	90,208	...	....	3.6	5.0
6–7	89,883	...	....	3.1	5.0
7–8	89,604	...	....	2.6	5.0
8–9	89,371	...	....	2.2	5.0
9–10	89,174	...	....	1.9	5.0
10–11	89,005	...	....	1.8	5.1
11–12	88,845	...	....	1.8	5.1
12–13	88,685	...	....	1.9	5.1
13–14	88,516	13	15.2	2.1	5.1
14–15	88,317	17	19.6	2.3	5.1
15–16	88,097	21	24.4	2.7	5.1
16–17	87,838	25	28.7	3.1	5.1
17–18	87,541	30	34.1	3.5	5.1
18–19	87,205	35	39.6	3.8	5.0
19–20	86,839	38	44.1	4.3	5.0
20–21	86,428	41	47.5	4.7	5.0
21–22	85,981	45	51.9	5.1	5.0
22–23	85,498	48	56.1	5.4	4.9
23–24	84,989	52	61.0	5.7	4.9
24–25	84,453	55	65.6	6.0	4.9
25–26	83,892	59	70.0	6.2	4.9
26–27	83,313	62	74.4	6.4	4.8
27–28	82,718	65	78.2	6.5	4.8
28–29	82,116	67	81.3	6.7	4.7
29–30	81,499	68	83.1	6.8	4.7
30–31	80,877	70	86.6	6.9	4.6
31–32	80,249	70	87.7	6.9	4.6
32–33	79,626	71	89.0	7.0	4.5
33–34	78,998	72	90.9	7.0	4.4
34–35	78,374	71	91.1	7.0	4.4
35–36	77,755	71	91.4	7.0	4.4

TABLE 4. EXPECTATION OF MENTAL DISEASE AMONG FEMALES IN NEW YORK STATE, 1920—(*Continued*)

Age interval, years	Of 100,000 persons born alive		Rate of mental disease per 100,000	Rate of mortality per 1,000	Expectation of mental disease
Period of lifetime between two exact ages	Number alive and sane at beginning of age interval	Number becoming mentally ill in age interval	Number becoming mentally ill during age interval among 100,000 alive and sane at beginning of age interval	Number dying in age interval per 1,000 alive at beginning of interval and remaining sane during interval	Number becoming mentally ill during remainder of life of 100 alive and sane at beginning of age interval
x to $x+1$	l_x	i_x	100,000 s_x	1,000 q_x	$t_x = \frac{\sum_{x}^{100} i_x}{l_x}$
36–37	77,140	71	91.6	7.0	4.3
37–38	76,530	70	91.8	7.0	4.3
38–39	75,925	70	92.1	7.1	4.2
39–40	75,316	70	93.1	7.1	4.1
40–41	74,712	70	94.0	7.2	4.1
41–42	74,105	70	95.0	7.4	4.0
42–43	73,487	71	96.1	7.6	4.0
43–44	72,858	71	97.2	7.8	3.9
44–45	72,219	71	98.4	8.1	3.8
45–46	71,564	71	99.8	8.5	3.8
46–47	70,885	72	101.2	8.9	3.7
47–48	70,183	72	102.7	9.3	3.6
48–49	69,459	72	103.6	9.8	3.6
49–50	68,707	72	104.5	10.3	3.5
50–51	67,928	72	105.6	10.9	3.4
51–52	67,116	72	106.7	11.6	3.4
52–53	66,266	71	107.1	12.4	3.3
53–54	65,374	70	107.8	13.3	3.2
54–55	64,435	70	108.1	14.3	3.2
55–56	63,445	69	108.4	15.4	3.1
56–57	62,400	68	108.9	16.6	3.1
57–58	61,297	67	109.3	17.9	3.0
58–59	60,134	66	109.6	19.1	3.0
59–60	58,921	65	110.1	20.4	2.9
60–61	57,655	64	110.5	21.8	2.9
61–62	56,336	62	110.6	23.4	2.8
62–63	54,957	63	114.0	25.3	2.8
63–64	53,505	63	117.8	27.5	2.7
64–65	51,972	65	125.8	30.1	2.7
65–66	50,345	68	134.7	33.0	2.6
66–67	48,618	68	140.4	36.1	2.6
67–68	46,797	69	146.4	39.4	2.6
68–69	44,887	69	152.8	42.9	2.5
69–70	42,895	68	159.5	46.7	2.4
70–71	40,827	68	166.7	50.9	2.4
71–72	38,684	68	174.6	55.3	2.4

TABLE 4. EXPECTATION OF MENTAL DISEASE AMONG FEMALES IN NEW YORK STATE, 1920—(*Continued*)

Age interval, years	Of 100,000 persons born alive		Rate of mental disease per 100,000	Rate of mortality per 1,000	Expectation of mental disease
Period of lifetime between two exact ages	Number alive and sane at beginning of age interval	Number becoming mentally ill in age interval	Number becoming mentally ill during age interval among 100,000 alive and sane at beginning of age interval	Number dying in age interval per 1,000 alive at beginning of interval and remaining sane during interval	Number becoming mentally ill during remainder of life of 100 alive and sane at beginning of age interval
x to $x+1$	l_x	i_x	100,000 s_x	1,000 q_x	$t_x = \frac{\sum_{x}^{100} i_x}{l_x}$
72–73	36,481	67	183.2	60.1	2.3
73–74	34,226	66	192.5	65.2	2.3
74–75	31,933	65	202.7	70.7	2.3
75–76	29,615	63	213.8	76.6	2.2
76–77	27,288	62	226.1	83.1	2.2
77–78	24,964	60	240.1	90.1	2.1
78–79	22,660	58	256.1	97.9	2.1
79–80	20,389	56	274.4	106.6	2.0
80–81	18,166	51	279.9	116.0	2.0
81–82	16,014	48	302.0	125.8	1.9
82–83	13,957	43	306.8	135.8	1.8
83–84	12,024	40	332.2	145.9	1.8
84–85	10,236	34	332.9	156.2	1.7
85–86	8,608	29	334.5	167.0	1.6
86–87	7,146	24	336.1	178.5	1.6
87–88	5,851	20	338.1	191.0	1.4
88–89	4,717	16	341.2	205.1	1.4
89–90	3,737	13	344.0	220.6	1.4
90–91	2,902	10	347.0	237.1	1.3
91–92	2,206	8	358.6	254.2	1.3
92–93	1,639	6	373.0	271.3	1.2
93–94	1,190	5	386.0	288.2	1.2
94–95	843	3	399.0	305.2	1.1
95–96	584	2	412.5	322.4	1.0
96–97	394	2	425.5	340.1	1.0
97–98	259	1	438.0	358.4	0.8
98–99	166	1	451.5	377.1	0.6
99–100	103	...	464.5	396.1	..
100–101	62	...	....	415.7	..
101–102	36	...	....	436.3	..
102–103	20	...	....	458.6	..
103–104	11	...	....	482.7	..
104–105	6	...	....	508.1	..
105–106	3	...	....	534.9	..
106–107	1	...	....	564.1	..
107–108	....	...	....	595.2	..

TABLE 5. EXPECTATION OF MENTAL DISEASE AMONG NATIVE MALES IN NEW YORK STATE, 1920

Age interval, years	Of 100,000 persons born alive		Rate of mental disease per 100,000	Rate of mortality per 1,000	Expectation of mental disease
Period of lifetime between two exact ages	Number alive and sane at beginning of age interval	Number becoming mentally ill in age interval	Number becoming mentally ill during age interval among 100,000 alive and sane at beginning of age interval	Number dying in age interval per 1,000 alive at beginning of interval and remaining sane during interval	Number becoming mentally ill during remainder of life of 100 alive and sane at beginning of age interval
x to $x+1$	l_x	i_x	100,000 s_x	1,000 q_x	$t_x = \frac{\sum^{100} i_x}{l_x}$
0–1	100,000	...	....	86.1	4.3
1–2	91,390	...	....	17.7	4.7
2–3	89,772	...	....	8.5	4.8
3–4	89,009	...	....	5.8	4.8
4–5	88,493	...	....	4.5	4.9
5–6	88,095	...	....	3.9	4.9
6–7	87,751	...	....	3.4	4.9
7–8	87,453	...	....	3.0	4.9
8–9	87,191	...	....	2.5	4.9
9–10	86,973	...	....	2.6	4.9
10–11	86,747	...	....	2.4	5.0
11–12	86,539	...	....	2.3	5.0
12–13	86,340	...	....	2.3	5.0
13–14	86,141	5	6.2	2.4	5.0
14–15	85,929	13	15.3	2.6	5.0
15–16	85,693	25	29.2	2.8	5.0
16–17	85,428	34	39.9	3.5	5.0
17–18	85,095	42	49.9	3.8	5.0
18–19	84,730	49	57.3	4.1	4.9
19–20	84,334	54	63.6	4.3	4.9
20–21	83,918	57	68.4	4.3	4.9
21–22	83,500	60	71.7	4.5	4.8
22–23	83,065	64	76.6	4.7	4.8
23–24	82,611	66	79.7	4.9	4.7
24–25	82,141	68	82.4	5.1	4.7
25–26	81,654	68	83.4	5.3	4.6
26–27	81,154	68	84.4	5.5	4.6
27–28	80,640	69	85.7	5.7	4.5
28–29	80,112	70	87.4	5.9	4.4
29–30	79,570	71	89.3	6.1	4.4
30–31	79,014	72	91.4	6.3	4.3
31–32	78,445	74	93.7	6.5	4.3
32–33	77,862	75	96.1	6.7	4.2
33–34	77,266	75	96.9	6.9	4.1
34–35	76,658	75	97.8	7.1	4.1
35–36	76,039	75	98.1	7.3	4.0

TABLE 5. EXPECTATION OF MENTAL DISEASE AMONG NATIVE MALES IN NEW YORK STATE, 1920—(*Continued*)

Age interval, years	Of 100,000 persons born alive		Rate of mental disease per 100,000	Rate of mortality per 1,000	Expectation of mental disease
Period of lifetime between two exact ages	Number alive and sane at beginning of age interval	Number becoming mentally ill in age interval	Number becoming mentally ill during age interval among 100,000 alive and sane at beginning of age interval	Number dying in age interval per 1,000 alive at beginning of interval and remaining sane during interval	Number becoming mentally ill during remainder of life of 100 alive and sane at beginning of age interval
x to $x+1$	l_x	i_x	100,000 s_x	1,000 q_x	$t_x = \frac{\sum_{x}^{100} i_x}{l_x}$
36–37	75,409	74	98.3	7.5	3.9
37–38	74,770	74	98.5	7.8	3.9
38–39	74,113	73	99.0	8.0	3.8
39–40	73,448	73	99.4	8.3	3.7
40–41	72,766	74	102.1	8.6	3.7
41–42	72,067	74	102.1	8.9	3.6
42–43	71,352	73	102.1	9.3	3.5
43–44	70,616	72	101.6	9.7	3.4
44–45	69,860	70	100.6	10.1	3.4
45–46	69,085	67	96.7	10.6	3.4
46–47	68,286	65	95.5	11.1	3.3
47–48	67,464	64	94.7	11.6	3.2
48–49	66,618	63	94.3	12.3	3.2
49–50	65,736	62	94.0	12.9	3.1
50–51	64,827	61	94.0	13.7	3.1
51–52	63,879	60	94.1	14.5	3.0
52–53	62,894	61	97.7	15.5	3.0
53–54	61,859	61	98.5	16.5	2.9
54–55	60,778	61	99.8	17.6	2.9
55–56	59,648	60	101.2	18.8	2.8
56–57	58,468	63	106.9	20.2	2.8
57–58	57,225	62	108.5	21.6	2.7
58–59	55,928	61	109.8	23.2	2.7
59–60	54,571	61	111.0	25.0	2.6
60–61	53,147	62	117.1	26.9	2.6
61–62	51,657	61	118.7	29.1	2.6
62–63	50,095	60	120.5	31.4	2.5
63–64	48,464	62	128.8	33.9	2.4
64–65	46,761	65	138.5	36.6	2.4
65–66	44,987	64	142.7	39.5	2.4
66–67	43,149	67	154.5	42.8	2.3
67–68	41,238	66	159.3	46.3	2.3
68–69	39,266	68	173.0	50.0	2.2
69–70	37,238	66	178.4	54.1	2.2
70–71	35,161	65	183.9	58.6	2.1
71–72	33,039	63	189.6	63.3	2.1

TABLE 5. EXPECTATION OF MENTAL DISEASE AMONG NATIVE MALES IN NEW YORK STATE, 1920—(*Continued*)

Age interval, years	Of 100,000 persons born alive		Rate of mental disease per 100,000	Rate of mortality per 1,000	Expectation of mental disease
Period of lifetime between two exact ages	Number alive and sane at beginning of age interval	Number becoming mentally ill in age interval	Number becoming mentally ill during age interval among 100,000 alive and sane at beginning of age interval	Number dying in age interval per 1,000 alive at beginning of interval and remaining sane during interval	Number becoming mentally ill during remainder of life of 100 alive and sane at beginning of age interval
x to $x+1$	l_x	i_x	100,000 s_x	1,000 q_x	$\mathring{e}_x = \frac{\sum_x^{100} i_x}{l_x}$
72–73	30,889	60	195.6	68.5	2.0
73–74	28,717	58	201.9	74.1	1.9
74–75	26,535	55	208.4	80.1	1.9
75–76	24,359	52	215.0	86.5	1.8
76–77	22,204	49	221.7	93.5	1.8
77–78	20,084	46	228.3	100.9	1.7
78–79	18,016	42	234.7	109.0	1.6
79–80	16,015	39	240.5	117.6	1.6
80–81	14,097	35	245.1	126.8	1.5
81–82	12,279	31	250.6	136.7	1.4
82–83	10,574	27	257.0	147.3	1.4
83–84	8,993	24	263.0	158.6	1.4
84–85	7,547	20	269.0	170.8	1.3
85–86	6,241	17	275.0	183.7	1.2
86–87	5,081	14	281.5	197.6	1.2
87–88	4,066	12	287.6	212.4	1.2
88–89	3,193	9	293.8	228.2	1.1
89–90	2,457	7	300.0	245.0	1.1
90–91	1,850	6	306.1	262.9	1.0
91–92	1,359	4	312.5	282.0	1.0
92–93	973	3	318.5	302.4	0.9
93–94	677	2	325.0	324.0	0.9
94–95	456	2	332.0	347.0	0.9
95–96	296	1	337.0	371.5	0.7
96–97	185	1	343.6	397.5	0.5
97–98	111	...	349.8	425.1	..
98–99	64	...	356.0	454.4	..
99–100	35	...	....	485.5	..
100–101	18	...	....	518.5	..
101–102	9	...	....	553.5	..
102–103	4	...	....	590.6	..
103–104	2	...	....	629.8	..
104–105	1	...	....	671.4	..
105–106	....	...	....	....	..

TABLE 6. EXPECTATION OF MENTAL DISEASE AMONG NATIVE FEMALES IN NEW YORK STATE, 1920

Age interval, years	Of 100,000 persons born alive		Rate of mental disease per 100,000	Rate of mortality per 1,000	Expectation of mental disease
Period of lifetime between two exact ages	Number alive and sane at beginning of age interval	Number becoming mentally ill in age interval	Number becoming mentally ill during age interval among 100,000 alive and sane at beginning of age interval	Number dying in age interval per 1,000 alive at beginning of interval and remaining sane during interval	Number becoming mentally ill during remainder of life of 100 alive and sane at beginning of age interval
x to $x+1$	l_x	i_x	100,000 s_x	1,000 q_x	$t_x = \frac{\sum_{x}^{100} i_x}{l_x}$
0–1	100,000	...	....	68.9	4.0
1–2	93,110	...	....	16.0	4.3
2–3	91,620	...	....	7.8	4.3
3–4	90,905	...	....	5.6	4.4
4–5	90,396	...	....	4.0	4.4
5–6	90,034	...	....	3.6	4.4
6–7	89,710	...	....	3.1	4.4
7–8	89,342	...	....	2.6	4.4
8–9	89,199	...	....	2.1	4.4
9–10	89,012	...	....	1.9	4.4
10–11	88,843	...	....	1.8	4.4
11–12	88,683	...	....	1.8	4.4
12–13	88,523	...	....	1.9	4.5
13–14	88,355	2	2.5	2.0	4.5
14–15	88,176	10	11.4	2.3	4.5
15–16	87,963	16	18.2	2.7	4.5
16–17	87,710	21	23.9	3.1	4.5
17–18	87,417	26	29.9	3.5	4.4
18–19	87,085	30	34.8	3.9	4.4
19–20	86,715	33	38.4	4.4	4.4
20–21	86,301	36	42.2	4.4	4.4
21–22	85,885	40	46.1	4.6	4.4
22–23	85,450	43	50.0	4.7	4.4
23–24	85,006	46	54.0	4.9	4.4
24–25	84,544	49	57.9	5.1	4.4
25–26	84,064	52	61.9	5.2	4.3
26–27	83,575	55	66.0	5.3	4.3
27–28	83,077	57	68.8	5.5	4.2
28–29	82,563	59	71.9	5.6	4.2
29–30	82,042	62	75.2	5.8	4.2
30–31	81,505	63	76.9	5.9	4.1
31–32	80,961	65	80.7	6.0	4.1
32–33	80,411	67	82.8	6.2	4.0
33–34	79,846	67	83.4	6.3	3.9
34–35	79,276	67	84.2	6.4	3.9
35–36	78,702	67	85.1	6.6	3.8

TABLE 6. EXPECTATION OF MENTAL DISEASE AMONG NATIVE FEMALES IN NEW YORK STATE, 1920—(*Continued*)

Age interval, years	Of 100,000 persons born alive		Rate of mental disease per 100,000	Rate of mortality per 1,000	Expectation of mental disease
Period of lifetime between two exact ages	Number alive and sane at beginning of age interval	Number becoming mentally ill in age interval	Number becoming mentally ill during age interval among 100,000 alive and sane at beginning of age interval	Number dying in age interval per 1,000 alive at beginning of interval and remaining sane during interval	Number becoming mentally ill during remainder of life of 100 alive and sane at beginning of age interval
x to $x+1$	l_x	i_x	100,000 s_x	1,000 q_x	$t_x = \frac{\sum_{x}^{100} i_x}{l_x}$
36–37	78,116	67	86.0	6.7	3.8
37–38	77,526	67	86.7	6.9	3.7
38–39	76,925	67	87.2	7.1	3.7
39–40	76,312	69	89.9	7.3	3.6
40–41	75,686	70	92.5	7.5	3.5
41–42	75,049	70	92.7	7.8	3.5
42–43	74,394	69	93.1	8.0	3.4
43–44	73,730	69	93.5	8.3	3.3
44–45	73,000	69	93.9	8.7	3.3
45–46	72,297	68	94.3	9.0	3.2
46–47	71,579	68	94.7	9.5	3.2
47–48	70,832	67	95.1	9.9	3.1
48–49	70,064	67	95.5	10.4	3.0
49–50	69,269	66	95.6	11.0	3.0
50–51	68,442	65	95.7	11.7	2.9
51–52	67,577	65	95.9	12.4	2.9
52–53	66,675	64	96.2	13.2	2.8
53–54	65,732	64	96.7	14.1	2.7
54–55	64,742	63	97.3	15.1	2.7
55–56	63,702	63	98.2	16.2	2.6
56–57	62,608	62	99.0	17.4	2.6
57–58	61,458	61	99.7	18.7	2.5
58–59	60,249	60	100.3	20.1	2.4
59–60	58,979	59	100.7	21.7	2.4
60–61	57,641	58	101.2	23.5	2.4
61–62	56,230	60	106.7	25.4	2.3
62–63	54,743	59	107.7	27.5	2.3
63–64	53,180	58	108.9	29.8	2.2
64–65	51,539	57	110.5	32.4	2.2
65–66	49,814	56	112.3	35.1	2.2
66–67	48,011	55	114.0	38.1	2.1
67–68	46,129	57	123.0	41.3	2.1
68–69	44,169	55	124.5	44.8	2.1
69–70	42,138	53	125.6	48.7	2.0
70–71	40,035	54	136.0	52.8	2.0
71–72	37,870	52	137.0	57.3	2.0

TABLE 6. EXPECTATION OF MENTAL DISEASE AMONG NATIVE FEMALES IN NEW YORK STATE, 1920—(*Continued*)

Age interval, years	Of 100,000 persons born alive		Rate of mental disease per 100,000	Rate of mortality per 1,000	Expectation of mental disease
Period of lifetime between two exact ages	Number alive and sane at beginning of age interval	Number becoming mentally ill in age interval	Number becoming mentally ill during age interval among 100,000 alive and sane at beginning of age interval	Number dying in age interval per 1,000 alive at beginning of interval and remaining sane during interval	Number becoming mentally ill during remainder of life of 100 alive and sane at beginning of age interval
x to $x+r$	l_x	i_x	100,000 s_x	1,000 q_x	$e_x = \frac{\sum_{x}^{100} i_x}{l_x}$
72–73	35,651	53	149.0	62.1	1.9
73–74	33,387	50	150.2	67.4	1.9
74–75	31,090	51	164.3	73.0	1.9
75–76	28,773	52	180.2	79.1	1.9
76–77	26,449	53	198.5	85.6	1.8
77–78	24,137	49	201.7	92.7	1.8
78–79	21,855	49	225.0	100.3	1.8
79–80	19,619	45	229.8	108.4	1.7
80–81	17,452	41	234.2	117.2	1.7
81–82	15,370	37	237.8	126.5	1.6
82–83	13,393	37	274.2	136.6	1.6
83–84	11,532	32	280.1	147.3	1.5
84–85	9,806	28	284.4	158.9	1.4
85–86	8,224	23	285.5	171.2	1.4
86–87	6,797	20	296.5	184.4	1.4
87–88	5,527	17	307.8	198.4	1.4
88–89	4,417	14	319.0	213.4	1.3
89–90	3,463	11	330.2	229.5	1.3
90–91	2,660	9	343.0	246.5	1.2
91–92	1,998	7	356.5	264.7	1.2
92–93	1,464	5	369.5	284.1	1.2
93–94	1,044	4	382.0	304.8	1.1
94–95	723	3	394.5	326.7	1.1
95–96	485	2	427.0	350.1	1.0
96–97	314	1	456.0	374.9	1.0
97–98	196	1	485.0	401.3	1.0
98–99	117	1	520.0	429.3	0.9
99–100	66	...	549.0	459.0	..
100–101	36	...	....	490.5	..
101–102	18	...	....	524.0	..
102–103	9	...	....	559.4	..
103–104	4	...	....	597.0	..
104–105	2	...	....	636.8	..
105–106	1	...	....	678.9	..

TABLE 7. EXPECTATION OF MENTAL DISEASE AMONG FOREIGN-BORN MALES IN NEW YORK STATE, 1920

Age interval, years	Of 100,000 persons born alive		Rate of mental disease per 100,000	Rate of mortality per 1,000	Expectation of mental disease
Period of lifetime between two exact ages	Number alive and sane at beginning of age interval	Number becoming mentally ill in age interval	Number becoming mentally ill during age interval among 100,000 alive and sane at beginning of age interval	Number dying in age interval per 1,000 alive at beginning of interval and remaining sane during interval	Number becoming mentally ill during remainder of life of 100 alive and sane at beginning of age interval
x to $x+1$	l_x	i_x	$100{,}000\, s_x$	$1{,}000\, q_x$	$t_x = \frac{\sum_{x}^{100} i_x}{l_x}$
0–1	100,000	...	....	84.3	5.4
1–2	91,570	...	....	17.6	5.8
2–3	89,958	...	....	8.5	6.0
3–4	89,193	...	....	5.9	6.0
4–5	88,667	...	....	4.6	6.0
5–6	88,259	...	....	4.8	6.1
6–7	87,835	...	....	3.9	6.1
7–8	87,492	...	....	3.4	6.1
8–9	87,195	...	....	2.8	6.1
9–10	86,951	...	....	2.4	6.2
10–11	86,742	...	....	2.2	6.2
11–12	86,551	...	....	2.1	6.2
12–13	86,369	...	....	2.2	6.2
13–14	86,179	...	....	2.5	6.2
14–15	85,964	52	60.2	2.8	6.2
15–16	85,671	74	86.1	3.3	6.2
16–17	85,315	90	106.0	3.8	6.1
17–18	84,901	102	120.6	4.3	6.1
18–19	84,434	105	123.9	4.7	6.0
19–20	83,933	112	132.9	4.8	5.9
20–21	83,409	110	131.8	5.3	5.8
21–22	82,858	108	130.9	5.3	5.7
22–23	82,311	107	130.5	5.4	5.6
23–24	81,760	107	130.3	5.4	5.5
24–25	81,212	106	130.0	5.5	5.4
25–26	80,660	104	129.2	5.6	5.3
26–27	80,105	101	126.4	5.7	5.2
27–28	79,548	98	123.4	5.8	5.1
28–29	78,989	97	123.0	5.9	5.0
29–30	78,426	97	124.0	6.0	4.9
30–31	77,859	96	123.4	6.1	4.9
31–32	77,289	96	123.8	6.2	4.8
32–33	76,714	96	124.9	6.4	4.7
33–34	76,128	95	124.4	6.5	4.6
34–35	75,539	93	122.6	6.7	4.5
35–36	74,941	93	124.0	7.0	4.4

TABLE 7. EXPECTATION OF MENTAL DISEASE AMONG FOREIGN-BORN MALES IN NEW YORK STATE, 1920—(*Continued*)

Age interval, years	Of 100,000 persons born alive		Rate of mental disease per 100,000	Rate of mortality per 1,000	Expectation of mental disease
Period of lifetime between two exact ages	Number alive and sane at beginning of age interval	Number becoming mentally ill in age interval	Number becoming mentally ill during age interval among 100,000 alive and sane at beginning of age interval	Number dying in age interval per 1,000 alive at beginning of interval and remaining sane during interval	Number becoming mentally ill during remainder of life of 100 alive and sane at beginning of age interval
x to $x+1$	l_x	i_x	100,000 s_x	1,000 q_x	$e_x = \frac{\sum_{x}^{100} i_x}{l_x}$
36–37	74,324	91	123.1	7.2	4.3
37–38	73,699	90	122.0	7.5	4.2
38–39	73,057	90	123.3	7.8	4.2
39–40	72,398	88	121.9	8.1	4.1
40–41	71,724	89	123.4	8.5	4.0
41–42	71,026	85	119.8	8.9	3.9
42–43	70,310	84	119.5	9.3	3.8
43–44	69,573	82	117.3	9.8	3.7
44–45	68,810	80	115.6	10.4	3.7
45–46	68,015	78	114.2	11.0	3.6
46–47	67,190	74	109.4	11.7	3.5
47–48	66,331	73	110.7	12.5	3.4
48–49	65,430	71	108.0	13.3	3.4
49–50	64,490	70	108.5	14.2	3.3
50–51	63,505	69	108.9	15.2	3.3
51–52	62,472	68	109.5	16.3	3.2
52–53	61,387	68	110.5	17.4	3.1
53–54	60,252	67	112.0	18.7	3.1
54–55	59,060	67	113.7	20.1	3.0
55–56	57,807	67	116.0	21.6	3.3
56–57	56,493	67	118.4	23.3	2.9
57–58	55,111	66	120.4	25.1	2.9
58–59	53,663	69	128.3	27.0	2.9
59–60	52,147	68	130.1	29.1	2.8
60–61	50,564	67	131.8	31.4	2.8
61–62	48,911	65	133.4	33.8	2.7
62–63	47,195	67	143.0	36.5	2.7
63–64	45,408	66	145.4	39.3	2.6
64–65	43,560	68	157.1	42.4	2.6
65–66	41,648	67	160.3	45.7	2.5
66–67	39,681	69	174.4	49.2	2.5
67–68	37,663	67	178.2	53.0	2.4
68–69	35,603	69	194.8	57.1	2.4
69–70	33,505	67	199.3	61.5	2.4
70–71	31,382	64	203.4	66.2	2.3
71–72	29,245	61	207.0	71.2	2.2

TABLE 7. EXPECTATION OF MENTAL DISEASE AMONG FOREIGN-BORN MALES IN NEW YORK STATE, 1920—(*Continued*)

Age interval, years	Of 100,000 persons born alive		Rate of mental disease per 100,000	Rate of mortality per 1,000	Expectation of mental disease
Period of lifetime between two exact ages	Number alive and sane at beginning of age interval	Number becoming mentally ill in age interval	Number becoming mentally ill during age interval among 100,000 alive and sane at beginning of age interval	Number dying in age interval per 1,000 alive at beginning of interval and remaining sane during interval	Number becoming mentally ill during remainder of life of 100 alive and sane at beginning of age interval
x to $x+1$	l_x	i_x	100,000 s_x	1,000 q_x	$t_x = \frac{\overset{100}{\Sigma}\, i_x}{l_x}$
72–73	27,106	57	209.6	76.6	2.2
73–74	24,977	53	210.4	82.4	2.2
74–75	22,870	53	232.1	88.5	2.1
75–76	20,798	50	239.0	95.1	2.1
76–77	18,775	46	247.0	102.1	2.0
77–78	16,817	43	254.3	109.5	2.0
78–79	14,937	40	271.0	117.5	2.0
79–80	13,147	38	287.5	126.0	1.9
80–81	11,457	33	291.0	135.0	1.9
81–82	9,882	30	306.0	144.7	1.9
82–83	8,426	28	327.1	154.9	1.8
83–84	7,097	24	334.0	165.8	1.8
84–85	5,900	21	360.5	177.3	1.7
85–86	4,837	18	370.5	189.6	1.7
86–87	3,905	15	378.0	202.7	1.6
87–88	3,101	12	386.0	216.5	1.5
88–89	2,420	9	390.5	231.2	1.4
89–90	1,854	7	392.5	246.7	1.4
90–91	1,391	6	433.0	263.2	1.4
91–92	1,020	5	449.4	280.7	1.4
92–93	730	3	464.0	299.2	1.2
93–94	509	2	479.0	318.8	1.2
94–95	345	2	493.0	339.5	1.2
95–96	227	1	511.0	361.4	0.9
96–97	144	1	629.0	384.6	0.7
97–98	88	...	547.0	409.1	..
98–99	52	...	564.0	435.0	..
99–100	29	...	572.0	462.4	..
100–101	16	...	....	491.2	..
101–102	8	...	....	521.7	..
102–103	4	...	....	553.9	..
103–104	2	...	....	587.8	..
104–105	1	...	....	623.6	..
105–106	0	...	....	....	..

TABLE 8. EXPECTATION OF MENTAL DISEASE AMONG FOREIGN-BORN FEMALES IN NEW YORK STATE, 1920

Age interval, years	Of 100,000 persons born alive		Rate of mental disease per 100,000	Rate of mortality per 1,000	Expectation of mental disease
Period of lifetime between two exact ages	Number alive and sane at beginning of age interval	Number becoming mentally ill in age interval	Number becoming mentally ill during age interval among 100,000 alive and sane at beginning of age interval	Number dying in age interval per 1,000 alive at beginning of interval and remaining sane during interval	Number becoming mentally ill during remainder of life of 100 alive and sane at beginning of age interval
x to $x+1$	l_x	i_x	$100{,}000\, s_x$	$1{,}000\, q_x$	$t_x = \frac{\sum_{x}^{100} i_x}{l_x}$
0–1	100,000	...	....	67.3	5.2
1–2	93,270	...	....	15.8	5.6
2–3	91,796	...	....	7.7	5.7
3–4	91,089	...	....	5.6	5.7
4–5	90,579	...	....	4.1	5.7
5–6	90,208	...	....	3.6	5.8
6–7	89,883	...	....	3.1	5.8
7–8	89,604	...	....	2.6	5.8
8–9	89,371	...	....	2.2	5.8
9–10	89,174	...	....	1.9	5.8
10–11	89,005	...	....	1.8	5.8
11–12	88,845	...	....	1.8	5.9
12–13	88,685	...	....	1.9	5.9
13–14	88,516	...	....	2.1	5.9
14–15	88,330	44	50.0	2.3	5.9
15–16	88,083	46	51.7	2.7	5.9
16–17	87,799	52	59.0	3.1	5.8
17–18	87,475	54	62.0	3.5	5.8
18–19	87,115	57	65.2	3.8	5.7
19–20	86,727	57	65.7	4.3	5.7
20–21	86,297	62	71.3	4.7	5.7
21–22	85,830	65	76.0	4.9	5.6
22–23	85,345	68	79.6	5.0	5.6
23–24	84,851	73	85.7	5.0	5.5
24–25	84,354	76	89.9	5.0	5.4
25–26	83,857	79	94.1	5.0	5.4
26–27	83,359	84	101.2	5.1	5.4
27–28	82,850	85	102.7	5.1	5.3
28–29	82,343	87	105.3	5.1	5.2
29–30	81,836	87	105.7	5.2	5.1
30–31	81,324	87	106.8	5.3	5.1
31–32	80,806	86	106.8	5.4	5.0
32–33	80,284	86	106.8	5.5	4.9
33–34	79,757	85	107.0	5.6	4.8
34–35	79,226	85	107.0	5.8	4.8
35–36	78,682	85	107.5	5.9	4.7

TABLE 8. EXPECTATION OF MENTAL DISEASE AMONG FOREIGN-BORN FEMALES IN NEW YORK STATE, 1920—(*Continued*)

Age interval, years	Of 100,000 persons born alive		Rate of mental disease per 100,000	Rate of mortality per 1,000	Expectation of mental disease
Period of lifetime between two exact ages	Number alive and sane at beginning of age interval	Number becoming mentally ill in age interval	Number becoming mentally ill during age interval among 100,000 alive and sane at beginning of age interval	Number dying in age interval per 1,000 alive at beginning of interval and remaining sane during interval	Number becoming mentally ill during remainder of life of 100 alive and sane at beginning of age interval
x to $x+1$	l_x	i_x	100,000 s_x	1,000 q_x	$t_x = \frac{\sum_{x}^{100} i_x}{l_x}$
36–37	78,133	84	107.5	6.1	4.6
37–38	77,573	83	107.6	6.3	4.5
38–39	77,002	83	108.0	6.6	4.4
39–40	76,411	83	108.0	6.9	4.4
40–41	75,801	82	108.5	7.2	4.3
41–42	75,174	82	108.5	7.6	4.3
42–43	74,521	81	109.0	8.0	4.2
43–44	73,844	80	109.0	8.5	4.1
44–45	73,137	80	109.5	9.0	4.0
45–46	72,399	85	117.1	9.6	4.0
46–47	71,620	84	117.6	10.2	3.9
47–48	70,806	83	117.8	10.9	3.8
48–49	69,952	85	122.0	11.7	3.7
49–50	69,050	84	122.0	12.6	3.7
50–51	68,096	83	122.0	13.5	3.6
51–52	67,095	82	122.0	14.2	3.5
52–53	66,061	81	122.3	15.7	3.4
53–54	64,944	80	123.1	16.9	3.4
54–55	63,768	76	118.9	18.3	3.3
55–56	62,526	75	119.9	19.8	3.3
56–57	61,214	74	120.9	21.4	3.2
57–58	59,832	72	121.0	23.1	3.2
58–59	58,380	71	121.6	25.0	3.1
59–60	56,851	69	122.0	27.1	3.1
60–61	55,243	69	124.8	29.3	3.1
61–62	53,557	68	127.7	31.7	3.0
62–63	51,793	70	135.4	34.3	3.0
63–64	49,949	72	143.7	37.1	3.0
64–65	48,027	73	152.8	40.1	2.9
65–66	46,031	75	162.7	43.4	2.9
66–67	43,962	76	173.6	46.9	2.9
67–68	41,828	78	185.7	50.6	2.8
68–69	39,637	78	198.0	54.7	2.8
69–70	37,395	80	214.4	59.0	2.8
70–71	35,113	76	217.0	63.6	2.7
71–72	32,809	77	234.9	68.6	2.7

TABLE 8. EXPECTATION OF MENTAL DISEASE AMONG FOREIGN-BORN FEMALES IN NEW YORK STATE, 1920—(*Continued*)

Age interval, years	Of 100,000 persons born alive		Rate of mental disease per 100,000	Rate of mortality per 1,000	Expectation of mental disease
Period of lifetime between two exact ages	Number alive and sane at beginning of age interval	Number becoming mentally ill in age interval	Number becoming mentally ill during age interval among 100,000 alive and sane at beginning of age interval	Number dying in age interval per 1,000 alive at beginning of interval and remaining sane during interval	Number becoming mentally ill during remainder of life of 100 alive and sane at beginning of age interval
x to $x+1$	l_x	i_x	100,000 s_x	1,000 q_x	$t_x = \frac{\sum^{100} i_x}{l_x}$
72–73	30,487	73	238.3	73.9	2.6
73–74	28,166	73	259.9	79.6	2.6
74–75	25,857	68	264.5	85.7	2.5
75–76	23,579	63	268.9	92.1	2.4
76–77	21,350	64	297.5	99.1	2.4
77–78	19,177	58	303.4	106.5	2.4
78–79	17,083	53	308.4	114.4	2.3
79–80	15,082	52	346.7	122.8	2.3
80–81	13,184	47	353.4	131.7	2.2
81–82	11,407	41	358.9	141.2	2.2
82–83	9,761	37	377.0	151.3	2.1
83–84	8,253	32	390.0	162.1	2.1
84–85	6,888	28	404.0	173.5	2.0
85–86	5,670	23	414.0	185.6	1.9
86–87	4,599	20	425.5	198.5	1.9
87–88	3,670	16	438.0	212.2	1.8
88–89	2,879	13	450.0	226.7	1.8
89–90	2,216	10	465.0	242.0	1.7
90–91	1,672	8	482.0	258.3	1.7
91–92	1,234	6	500.0	275.6	1.6
92–93	890	5	523.0	293.8	1.6
93–94	625	3	547.0	313.2	1.4
94–95	427	2	572.0	333.6	1.4
95–96	283	2	598.0	355.2	1.4
96–97	181	1	624.0	378.1	1.1
97–98	112	1	648.0	402.2	0.9
98–99	66	...	680.0	427.7	0.6
99–100	38	...	710.0	454.7	..
100–101	21	...	....	454.7	..
101–102	11	...	....	513.2	..
102–103	5	...	....	544.8	..
103–104	2	...	....	578.3	..
104–105	1	...	....	613.5	..
105–106	....	...	....	....	..

ABSTRACTS

On Some of the Relationships of Endocrinology to Psychiatry. By Lewellys F. Barker, M.D. *Hospital Social Service,* 17:377–88, May, 1928.

Doctor Barker approaches his subject from three angles. He discusses (1) abnormal mental manifestations found in association with outspoken diseases of the endocrine apparatus; (2) endocrine disturbances manifested by patients suffering from outspoken mental diseases; and (3) the relation of the endocrine functions to the physiology and pathology of the human constitution and, in turn, the relation of constitutional make-up to psychoneurotic and psychotic reaction types.

The principal endocrine glands are the thyroid, the parathyroids, the hypophysis cerebri or pituitary gland, the epiphysis cerebri, the islands of Langerhans in the pancreas, the thymus gland, the chromaffin system, the interrenal system, and the gonads or genital glands.

Reviewing briefly the more important disorders of these glands, Doctor Barker mentions as the most striking diseases of the thyroid (1) myxœdema, resulting from absence or under-function of the gland, and (2) Graves' disease or exophthalmic goiter, presumably due to over-function. In myxœdema, besides the familiar physical symptoms—the dry and wrinkled skin, the falling out of the hair, the tendency to obesity, the slowed digestion and excretion and retarded basal metabolic rate, the clumsiness and stiffness of movement, the sensitiveness to cold—there are on the mental side the apathetic, expressionless look, the drowsiness, the dullness of sensation and of apperception, the poverty of thought and lack of feeling. Graves' disease, with its characteristic protrusion of the eyeballs and swelling and pulsation of the thyroid gland, presents in many ways a contrasting group of symptoms—rapid pulse and accelerated basal metabolic rate, tendency to emaciation, unbearable feeling of heat, excitable vasomotors, look of anxiety, hypersensitiveness to psychic stimuli, irritability, restlessness, and insomnia. Patients suffering from Graves' disease often show also character anomalies, pathological ideas of injury, and phobias, and sometimes a maniacal excitement resembling that observable in cyclothymic states.

Removal or under-function of the parathyroid glands results in tetany, with its typical tonic spasms. There is increased electrical excitability of the muscles and nerves and increased mechanical

excitability. In chronic tetany, there are profound disturbances of nutrition, manifested in alterations in the enamel of the teeth, perinuclear cataracts in the eye, and certain abnormal psychic manifestations, such as irritability, easy fatiguability, and increased need of sleep. Tetany has also a profound effect upon the chemistry of the blood; there is instability of the acid-base equilibrium and the calcium content is diminished.

As in the case of the thyroid, diseases of the hypophysis cerebri or pituitary gland present two contrasting groups of symptoms corresponding respectively to over-function and under-function of the gland. Characteristic of the first condition, so-called acromegaly, are the hexagonal face, the "nutcracker" profile, the projecting cheek bones and supraorbital arches, the spadelike hands with sausage-shaped fingers, the enlarged feet, and the curvature of the spine. Associated with this condition we sometimes find psychotic manifestations that are not unlike those encountered in the manic phases of cyclothymic states. Under-function of the gland, known as dystrophia adiposogenitalis or Frohlich's syndrome, is associated, especially when it has been present in early life, with a peculiar form of obesity—the fat being particularly abundant on the upper arms and thighs and about the breasts and abdomen—with a general hypotrichosis or lack of hair on the body, and with failure of the secondary sex characteristics to develop normally. In patients of this type the psyche is almost always somewhat subnormal. There is apt to be a slight reduction of the mental powers and a tendency to euphoria, or elation, which often, however, is associated with drowsiness and heaviness.

Under-function of the internal secretory apparatus of the pancreas (the islands of Langerhans) results in diabetes mellitus, with glycosuria and hyperglycemia. While diabetic patients may show some disturbances of the psyche, these manifestations are so irregular that their relation to the under-functioning of the pancreas is not clear. As worthy of note in this connection, Doctor Barker mentions the fact that too large a dose of insulin administered to a diabetic patient may result in insulin shock or a hypoglycemic crisis—that is, too much sugar may go out of the blood. He cites one case of this kind in which there were sudden narcoleptic attacks of several hours duration. The patient's blood sugar was found to be at a very low level during these attacks. They could be arrested promptly by the administration of glucose.

The close relation between the gonads or sex glands and the psyche is evident in the deviations from the normal of the eunuch, whose sex glands have been removed, and the so-called "eunuchoid", in whom they have failed to develop normally. Besides the bodily

abnormalities that such patients show, many of them also develop antisocial or asocial behavior; they may exhibit criminal tendencies, labile affective states, a peculiar taciturnity, and a tendency to isolation. In women the relation of menstruation and the menopause to abnormal mental states is well known even to laymen.

Diseases of the suprarenal glands present clinical pictures that vary according as the medulla (or chromaffin part) or the cortex (or interrenal part) is diseased. The chromaffin part produces epinephrin (adrenalin), which is a sensitizer of the sympathetic nervous system. Disorders of the interrenal part are again of two types, corresponding to destruction or underactivity of the part, on the one hand, and to overactivity on the other. When both parts of the suprarenal glands are injured, the clinical picture of Addison's disease results, with its low blood pressure, great weakness, and easy fatiguability. Such patients show also low emotional tension, with tendencies to anxiety, to phobias, and to querulousness. In marked contrast to these asthenic symptoms of Addison's disease are the so-called "sthenic phenomena" that accompany overactivity of the interrenal part of the suprarenal system, individuals with this condition often showing abnormal psychic as well as physical vigor.

In view of the close relationship between the functions of the endocrine glands and the tonus of the vegetative nervous system and, in turn, between the functions of the vegetative nervous system and affective states, it is not surprising that disturbances of the endocrine functions should be associated with abnormal moods and abnormalities of character and temperament. When the disturbances are particularly severe, symptomatic psychoses may develop that are indistinguishable from the exogenous or toxi-infectious psychoses of Bonhoeffer, the patients suffering from illusions, hallucinations, disorientation, and delirious confusion. In other cases, the psychotic pictures resemble closely those encountered in the endogenous psychoses, such as manic-depressive insanity, dementia praecox, and epilepsy.

Passing on to his second point—a consideration of what endocrine disturbances, if any, are manifested by psychotic patients—Doctor Barker states that while mild disturbances of the endocrine functions are not uncommon in the major psychoses, many such psychoses occur without any outspoken symptoms referable to endocrine disorders. Moreover, autopsy studies of the endocrine glands in persons who manifested major psychoses during life have not demonstrated the existence of any constant or characteristic changes. The fact that certain manic states resemble the psychic disturbances sometimes encountered in Graves' disease, while certain depressive states are similar to the psychic disturbances observable in myxœdema, gave rise to the

theory that manic-depressive insanity might be connected with dysfunction of the thyroid. But the data thus far available give little support to this view. Rather, it is an illustration of "the danger of assuming genetic relationships from similarities of symptomatology. That is not to say", Doctor Barker adds, "that the endocrine glands during development may not have helped to give a constitution predisposing to manic-depressive insanity; but it does not seem at all likely that any acute disturbance of the endocrine glands is responsible for the outbreaks of manic-depressive insanity (mania or melancholia) in adults."

Another theory, which has been widely promulgated, is that a disturbance of the internal secretion of the gonads is an important etiological factor in dementia praecox. This theory was based largely upon the fact that the onset of dementia praecox so often coincides with the period of puberty. Moreover, studies with Abderhalden's tests seemed for a time to point in the same direction. But sober consideration of the data available leads to the conclusion that the influence of the gonads in dementia praecox has been greatly exaggerated. In the first place, further studies of Abderhalden's reaction have shown the fallacy of basing far-reaching conclusions upon its results. In the second, it is a mistake to attribute the whole puberty psyche to the effects of the internal secretions of the gonads. This secretion undoubtedly has an effect in that it erotizes the body, but the puberty psyche is a much more complex affair than mere erotization. In the third place, the onset of dementia praecox is not necessarily coincident with the advent of puberty.

Doctor Barker is also of the opinion that far too much stress has been laid upon the possible rôle of the internal secretions in the origin of idiopathic epilepsy. It is true that a tendency to elementary spasm is encountered in a whole series of endocrine diseases, but constitutional epilepsy is too complex a problem to be explained by any endocrine data available at present.

The theory that the endocrine glands play a part in the symptomatology of the toxi-infectious psychoses seems not implausible. The similarity of the symptoms in these psychoses, the fact that different kinds of exogenous stimuli produce similar reactions, warrants the theory that there must be intermediate links in the disease process interpolated between the poisons from the outside and the psychic reactions. It is not impossible that the endocrine glands are these links and that their transformation of the heterogeneous stimuli accounts for the similarity of the reactions manifested in very different intoxications and infections. Since the psychoses often encountered in severe endocrine diseases are symptomatically indistinguish-

able from the psychoses that follow various sorts of exogenous poisoning, the suggestion has been made that the external poisons do not act upon the brain directly, but only through the mediation of the endocrine glands. This theory is interesting, but not yet proven.

The idiocies and imbecilities of early life can sometimes be directly related to injuries of the endocrine glands or to anomalies of their development. For example, in certain childhood infections, an acute thyroiditis may develop, hereditary syphilis often involves the pituitary gland, and other infections sometimes implicate the thymus; and such infections may be followed by disturbances in the development of the nervous system that are associated with idiocy and imbecility. Again, cretinism is common in regions where iodine, an activator of the thyroid gland, is lacking in the food or water. But cretinism is something more than mere thyroid insufficiency. Cretins are benefited by the administration of thyroid extract, but not nearly so much as children suffering from simple myxœdema. Attempts have been made to establish a glandular basis for other types of idiocy and imbecility, also, but while the relation of internal secretions to growth and development is undoubtedly very important, the whole subject is so complex and so little is known as yet about the interrelationships of the glands, that theories as to the exact disturbances that are responsible for individual types are little more than guess work. Popular treatises to the contrary notwithstanding, it is not possible to write down the "endocrine formula" of any given constitution or personality. Especially to be emphasized is the fact that for the majority of idiots and imbeciles, endocrine therapy is of no real value. "There has been nothing more tragic in my experience", Doctor Barker states, "than to have parent after parent come to me with an imbecile child or an idiot, thinking that if I could only find the particular gland of internal secretion that was faulty, the child's mind could be restored to normal."

Attempts to explain differences in constitution as due to varying "endocrine formulæ" are, as has been said, premature. But there is some evidence that during development "neuro-hormonal" mechanisms are formed that have a great deal to do with determining what kind of reactions, both physical and psychical, the individual will exhibit. Interesting attempts have recently been made to correlate physical types of constitution with mental reaction types. Two contrasting physical types have been distinguished—the pyknic, with a round or pentangular face and a tendency to obesity, and the asthenic, with an oval or elongated face, long neck and extremities, a tendency to emaciation, and low blood pressure. It is said that the pyknic type have a tendency toward the so-called cycloid or extrovert personality,

and that when they develop mental disease, it is frequently of the manic-depressive form. The asthenic type, on the other hand, is said to be more often associated with a personality of the schizoid or introvert type and with the schizoid type of psychosis. Pure pyknic and pure asthenic types are, however, rarely encountered. Most persons are mixtures of both with, perhaps, one or the other predominating. The so-called dysplastic types of constitution show marked deviations from both the pyknic and the asthenic type. It is probable that the endocrines play some part—possibly a very important part—in the origin of all these types. If so, it would seem that the "endocrine formula" deviates further from the average in the dysplastic than in the other types.

The whole subject of the relation of constitution to the endocrine apparatus, on the one hand, and to mental reaction types on the other, is highly controversial. It remains to be seen how far studies in this field will add to our understanding of human beings. Many persons are of the opinion that too much emphasis is being placed upon them. But if this is the case, corrective influences will sooner or later make their appearance, and in the meantime it is perhaps desirable that they should be pushed as far as is legitimate in the hope that they may add to our knowledge.

BOOK REVIEWS

THE UNCONSCIOUS; A SYMPOSIUM. Papers by C. M. Child, Kurt Koffka, John E. Anderson, John B. Watson, Edward Sapir, W. I. Thomas, Marion E. Kenworthy, F. L. Wells, and William A. White, with an Introduction by Ethel S. Dummer. New York: Alfred Knopf, 1927. 260 p.

"After many centuries, the unconscious, which has hitherto been the realm of the mystic or the mesmerist, is now being claimed for science", says Mrs. Dummer in introducing this symposium, which is much more than merely another contribution to the scant literature in this field and far more satisfying than the ordinary symposium of popular heterogeneous comments. Evidently the contributors to this discussion were left free to approach it from the angle of their own interest, to take from their own fields whatever facts or concepts might have value for this subject. Curiously, out of these widely different approaches—from biology, psychology, psychiatry, psychoanalysis, anthropology, sociology—even out of such antagonistic points of view as behaviorism and psychoanalysis, certain unities emerge.

The first, most striking unity, due to Mrs. Dummer and to Professor W. I. Thomas, organizer of the conference, grows out of the uniformly distinguished character of the contributors and the seriousness with which each approaches his topic—a relief from several recent symposiums marred by some popular unprepared speeches lacking both in material and organization. The unity of *The Unconscious* extends even beyond the organization of the individual speech in a spirit created by Mrs. Dummer in her introduction and remaining with the reader through the various articles, as it no doubt permeated the atmosphere of the conferences. This spirit can be captured only by reading in full Mrs. Dummer's introduction, by no means the least distinguished contribution to the book, in which she gives the evolution of her own interest in the field of mental hygiene, an interest that has been so tremendously creative and productive. No principles sufficiently synthetic to satisfy Mrs. Dummer's own vision of the "unity of life", "the synthetic activity of the unconscious", are realized completely in these articles, though Professor Child's theory of organismic pattern, Dr. White's theory of the solution of conflict through integration, and the *Gestalt* theory of creative intelligence go far in articulating dynamic, organic points of view in which

ancient distinctions between organism and environment, conscious and unconscious, part and whole are transcended.

The editor's arrangement of the series, at least to the extent of setting Professor Child's article at the beginning and Dr. White's at the close, serves again to point out the underlying unity of the book. Other articles make no contribution to the problem of the integrative activity of the unconscious, but examined apart from their bearing upon this major interest and organizing idea of the editor's, each article makes its own contribution to the specific topic it discusses. Professor Child's article, *The Beginnings of Unity and Order in Living Things,* for example, is a clear exposition of his brilliant and illuminating theory of the organism as a pattern of reaction to environment appearing in protoplasm, of the physiological gradient as the carrier of the record of behavior. The reader who does not already know Professor Child's technical works will be at once led to his book, *Physiological Foundations of Behavior,* and its companion by Professor Herrick, *Neurological Foundations of Behavior,* but the essential meaning of their contribution is compacted into these thirty pages. Of the article by Dr. Koffka, stimulating and suggestive as it is, one would say that it forces further study of the findings of the *Gestalt* school for an understanding of the dynamic action of the *Gestalt*—traces in the thought process. We look forward to Dr. Köhler's book, announced for the fall, in the hope that it will supply further exposition of this fruitful point of view.

To a practical, scientific analysis of behavior, its earliest social conditioning in the family group, its unconscious and conscious patterning aspects, its individual and its social aspects, Anderson, Sapir, and Thomas make interesting contributions. Particularly suggestive for psychiatrists, diagnosing always in terms of one culture pattern, is Professor Sapir's analysis of the unconscious patterning of behavior in accordance with the organized forms of differing culture patterns, his illustration from linguistic behavior being especially interesting.

Dr. Watson and Dr. Kenworthy also contribute to this effort to analyze the unconscious factors in behavior, and if we may take the risk of combining the points of view of the leading exponent of Behaviorism and an exponent of the Rankian school of psychoanalysis, we may arrive at perhaps a more scientific concept of the unconscious than has yet been achieved. In Watson's article—apart from the introduction, with its regrettable attack on Freud, and the conclusion, with its naïve assumption that behavior and ethical problems will be simplified, if not completely solved, if the laryngeal segment (verbal organization) can be made dominant—we find, in

his conception of the unverbalized, a new and safe starting point for a non-metaphysical concept of the unconscious. One gladly accepts his elaboration of the unverbalized to include all the early behavior that takes place before the child begins to verbalize, the large field of behavior that remains action and never becomes articulated in words, and, finally, the world of the emotions, "the happenings and goings-on in our body and the mechanical, chemical, and glandular stimuli which call forth these happenings". If we take the liberty of using Dr. Watson's term and stretching it backwards to include the behavior of the fetus before birth, described in Dr. Kenworthy's article, we have as behavioristic and scientific a concept of the unconscious as one can find, elastic enough, also, for all psychoanalytic uses. Dr. Kenworthy's article has unique value in that for the first time in English,[1] it brings together in one place all that is known of the behavior of the fetus in the uterus and the effect of changes in the mother's attitude and behavior during pregnancy upon the development and comfort of the child. Here also is a discussion of the birth process as experience for the child and speculations as to the effects upon it of variations in this process. The article goes far deeper into an understanding of the meaning of unverbalized experience for the child and its profound and far-reaching after-effects in emotional life and behavior than Dr. Watson, with his over-simplified conceptions, would be willing to follow.

F. L. Wells brings to attention through delightful references many ambivalent points of view.

In conclusion, Dr. White leads into that most profound metaphysical problem—with which Freud is so preoccupied at present—of the conflict between the ego and the sex instincts, but solves it with his characteristic optimism through a theory of emergent evolution. "The theory of emergent evolution, therefore, from the mental-hygiene point of view, means that for every new adjustment, every solution of an intrapsychic conflict that raises the level of adjustment, a new world, small or large as the case may be, opens to view, with all the possibilities that implies for a fuller life." (Page 250.) "Conflict of ego and libido strivings is at the very basis of life, of consciousness, as well as unconscious life. As man gains more and more use of this new tool of consciousness, the next most significant emergence for him will be a realization that knowledge of himself is of at least equal importance with a knowledge of his environment. The source and origin of the emergency which we must avail ourselves of for progress

[1] Dr. Otto Rank's work in this field, *The Trauma of Birth*, is in process of translation.

must remain in the depths of our unconscious, but it will be for us to understand its nature and learn to direct it towards constructive ends." (Page 260.)

The reviewer leaves this book with only one regret—that it does not include an article by Dr. John Dewey, whose point of view of experience, presented in *Experience and Nature,* has an essential contribution to make to the place of the unconscious in life.

VIRGINIA P. ROBINSON.
The Pennsylvania School of Social and Health Work.

PSYCHOLOGY: ITS FACTS AND PRINCIPLES. By Harry L. Hollingworth. New York: D. Appleton and Company, 1928. 539 p.

This new work of an author who has already written several notable volumes on more special branches of psychology develops in detail his central concept of redintegration, applying it to the material of general psychology. The book is termed by the author a "systematic, descriptive account of mental phenomena and of psychological processes", the former being defined as subjective events, the latter as redintegrative sequences in nature. The point of view, terminology, and principles of description and explanation employed will be familiar to those who have read *The Psychology of the Functional Neurosis, The Psychology of Thought, Mental Growth and Decline,* or other of Professor Hollingworth's writings. The material here presented is very largely new, however, and more fully developed.

As the author himself points out, the point of view is not strictly that of any of the contemporary schools. It is dynamic, since it deals with activities, processes, and occurrences. It is descriptive, but not "structuralist". It includes much objective or behavioristic data, but is not limited to this, and it "shuns the visual bias of behaviorism". Its resemblance to associationism is only superficial. There is little reference to the nervous system, unity and coherence of treatment being sought rather in the principle of the redintegrative sequence, which is "at once, the criterion, the mechanism, and the dynamics of mind". The principle of redintegration, the potency of antecedent details, the gradual reduction of cues, applies both to mental phenomena and to psychological processes.

The "psychophysical continuum" is defended in the treatment of the difficult problem of differentiating between subjective and objective events. The author holds that there is no sharp dichotomy between the two, but rather a continuous gradation, with relative consistency of report the criterion of objectivity. Both

types of event, including many of difficult or doubtful classification, are proper subject matter for psychology.

There is a rather full discussion of the laws of redintegration. Much of this material has, in other formulations, been treated as association, conditioning, learning, and engram. In the light of the general principles laid down, Professor Hollingworth proceeds to the discussion of special topics. There are chapters on language, the psychology of perception, ideas—particularly in their relation to thought and meaning and their consequents in mental activity—the perception of spatial situations, and social aspects of perception. These are followed by accounts of learning, memory, and imagination, dream and invention. The chapters on motivation, the dynamics of mental activity, the consequents of mental activity, association, habit and instinct, and craving, feeling, and emotion are particularly illuminating, up-to-date, and carefully worked out. Discussions of the psychology of reasoning and the phenomena of attention, voluntary action, and decision, a short discussion of the special senses, and a chapter on intelligence, character, and temperament conclude the text proper.

An abundance of illustrative material is given, much of it drawn from the experimental literature. The choice of material is excellent, covers a wide range, and represents work from many divergent interests and points of view.

The appendices contain very useful material. There are the classifications of affects, impulses, tendencies, emotions, and instincts proposed by Warren, Dunlap, McDougall, Thorndike, and Seashore, as well as by the author himself. The section entitled *Projects, Questions, and Exercises* should prove valuable in course work. A brief annotated bibliography for each chapter of the text affords a good orientation in the literature of the subject under consideration.

The volume is a very interesting and readable survey of the principal facts and problems of contemporary psychology. The author has attempted, with considerable success, to synthesize a great mass of material, very largely around his central concept of the redintegrative sequence. The systematic treatment, and to a considerable extent the terminology, bear the stamp of the author's special point of view and individuality. This is hardly avoidable, and not undesirable. Taken as a whole, the work seems to the reviewer a consistent and coherent account of the central facts and principles of a scientific psychology.

EDWARD N. BRUSH.

Boston Psychopathic Hospital.

THE NEW CRIMINOLOGY; A CONSIDERATION OF THE CHEMICAL CAUSATION OF ABNORMAL BEHAVIOR. By Max Schlapp, M.D., and Edward H. Smith. New York: Boni and Liveright, 1928. 325 p.

There is a story told in various forms to the effect that an Oriental marriage broker was attempting to convince a prospective bridegroom of the virtues of one of his clients. He had extolled her so highly that the suspicious customer inquired if it were not possible that she had just one little flaw. Very reluctantly, then, the marriage broker conceded that it was true that the girl was "just a little bit pregnant".

This story illustrates precisely the case of this book. It is the child of a psychiatrist and a newspaper man, and the child inherits virtues and vices from both. In places, it is an excellent presentation of the point of view of the more progressive students of criminology; it carefully and convincingly analyzes the evolutionary trend of free-will concepts and penal systems and psychiatric attitudes. It is written in a clear, readable style. Laymen will understand it easily and profit by reading it.

It has, however, as implied, a damning fault. Like that of the marriage broker's client, it is a subtle fault, the seriousness of which is not likely to be grasped by the superficial reader. It is a fault that is rather foreshadowed on the title page. In the first place, under the title, *The New Criminology,* is the subhead, *A Consideration of the Chemical Causation of Abnormal Behavior,* and under Mr. Smith's name is the statement that he is the author of, among other things, *Famous Poison Mysteries.*

Now this propensity for explaining everything on a chemical basis utterly ruins the book. As all physicists, chemists, and philosophers are perfectly willing to concede, it is theoretically possible that the whole universe is translatable into chemical terms. The fact is, however, that we are a very long way from knowing the formulæ for doing this. This is particularly true of human behavior. Parsifal, Hamlet, the activities of Wall Street, the candidacy of Al Smith, and the murder of Marian Parker may indeed be explicable in terms of chemistry, but to imply that we are anywhere near such an explanation is an unforgivable scientific crime. Whether this has come about through over-enthusiasm on the part of Dr. Schlapp for endocrine theories, or the exercise of Mr. Smith's propensities for investigating the effects of poisons, can only be conjectured. The fact of the matter is that the book as a whole gives an utterly false, misleading, and dangerous conception. How does this come about?

The authors first trace the development of the philosophy of behavior in a compact, yet eloquent and comprehensive fashion. They pay full tribute to the developments of psychiatry, psychology, and

psychoanalysis, and attack with proper bitterness the profitable cruelties of the older criminology and the stupidities and inefficacies of the present criminal and penal procedure. There are condensations of whole volumes of research into such clear and apt sentences as this: "As a matter of accuracy, many of the same unfortunates whom the witch-hunters and demon-exorcisors were burning in the Seventeenth Century are being condemned to prison in the Twentieth." And: "The brief interviews in cells and pens which now pass for psychiatrical examinations of accused slayers are a disgrace to our culture and the contrary opinions and crass wranglings of physicians employed by the defense and the state are an insult to the profession and to mental science. The day will come when any man accused of a homicide will be examined by an unbiased board of psychiatrists and researchers, who will use all the latest kowledge and apparatus and will render a decision wholly impartial and binding upon the courts. Judges, lawyers, jurors, and murderers all will likely combat such a move, but it will be made eventually because decency and public safety will require it."

The book soon runs into the morass one could expect from the prejudices announced on the title page. The author divides criminals into the mentally deficient and the intelligent. This all psychiatrists will deplore at the outset. It has been repeatedly demonstrated that there is no direct, accessible relationship between intelligence and crime, unless it is that a larger percentage of the more intelligent offenders escape arrest and conviction. In other words, there is no higher percentage of feeblemindedness among criminals than among non-criminals. Such a classification, therefore, is of no more logical value than a division of criminals into those arrested on Sunday and those arrested on week days. The authors' obvious reason for making it is to emphasize the chemical bases for feeblemindedness. Now it is true that there are some forms of feeblemindedness that are due to disorders in the chemistry of the glands of internal secretion, but these are greatly in the minority. It is also true that some types of feeblemindedness are hereditary, and that the transmission of heredity might theoretically be conceived of in chemical terms. The fact is, however, that for the most part heredity is understood in terms of chromosomes and unit characters or genes attached thereto, and while the chemistry of the body undoubtedly influences these and is influenced by them, we are by no means in a position to assume, as do the authors, that because a few criminals suffering from glandular disorders have responded to endocrine treatment, such treatment is a solution for the crime problem. Yet the authors say that "many hundreds of cases of incipient, active, and even confirmed

criminals have been successfully treated, normalized, and restored to society''. They have just stated, however, that their claims have been based on the study of over thirty thousand cases.

They leave this section to get themselves into even worse difficulties by attempting to explain stealing and murder on the basis of glandular and chemical abnormalities in the body, illustrating by a few cases. In the first place, a few cases would not be accepted by any scientist as proof of a theory, and in the second place, the cases they have given could be used to prove any one of half a dozen theories, depending upon the emphasis given.

Granted, however, that the authors have chosen poor cases, have used them only as illustrations, and have attempted to carry a theory too far, why is it fair to say that their book is dangerous? The book is dangerous and a definite setback to the very thing that its authors attempt to forward for the reason that all of the opponents of psychiatry in the field of criminology will use this book as an example of unsubstantiated claims, of exaggerated theories, and of a desire on the part of psychiatrists to do something that psychiatrists in general do not desire or claim to do. The psychiatric attitude, so far as criminology is concerned, is *not* to cure criminals. The expression ''curing criminals'' is a red flag to many of the opponents of psychiatry, who allege that psychiatrists are a bunch of emotionalists who are attempting to apply their little knowledge of medicine to the rescue of fallen souls not worth saving. Dr. Schlapp and Mr. Smith have given these gentlemen some fine ammunition. As a matter of fact, they are dead wrong. As private practitioners, psychiatrists are out to help their patients, or their patients' relatives, in the various ways medical science has developed. As criminologists, however, psychiatrists are anxious to put their services at the disposal of the authorities that the public has designated in order to protect that public against the ravages of the antisocially inclined, about whom psychiatrists justifiably believe themselves to be better informed than any one else. Because once in ten thousand cases some unlucky psychiatrist is dragged into the court room to say what he honestly can of the mental condition of a patient concerning whom he has been personally consulted, psychiatrists have been damned all over the country as having no social conscience. As a matter of fact, psychiatrists have shouted themselves hoarse telling the public that politicians and parole boards and judges are still stupidly releasing from prison people whom any psychiatrist could have told them should have never been released, that judges have been sentencing for two or three years offenders whose make-up indicates a lifelong propensity for viciousness and dangerousness. Psychiatrists have never claimed,

or offered, to cure criminals, not because we think it can't be done, but because we think that it is not the problem and that to talk about it is to shift interest from the public to the much less important consideration—namely, the criminal. If Dr. Schlapp, or any one else, can cure criminals, or can cure one in a hundred criminals, we are all glad of it, but most of us are much more vitally concerned with what to do with the other ninety-nine. To say that Dr. Schlapp represented psychiatrists is untrue; no one can deny that Dr. Schlapp was himself a psychiatrist and a good one, but in no sense does his book represent the prevalent opinion of psychiatrists. This opinion they have repeatedly expressed in official public documents, and fortunately it has at last been recognized to some extent by the National Crime Commission and the American Bar Association. Unfortunately, this book will not advance the cause one whit, not because it does not contain much that is true, but because it contains this little that is false.

Topeka, Kansas. KARL A. MENNINGER.

THE LOCOMOTIVE GOD. By William Ellery Leonard. New York: The Century Company, 1927. 434 p.

If one were to fill some four hundred pages describing in minute detail a bodily ill — for instance, spinal dislocations — who, I ask, would be interested in one's sufferings, except perhaps a technician? In reading *The Locomotive God,* one is inclined to feel that if the author had not displayed his literary talents elsewhere, his publishers might have sympathically suggested consultation with a physician instead of with a publishing house.

The book is a presentation of Professor Leonard's case of *agoraphobia,* which has restricted him for about fifteen years to the confines of his home in Madison, Wisconsin, and its immediate environs. The psychopathologist will hardly find in this presentation any new or startling revelations—or anything, in fact, that he does not find in his daily visits to his clinic.

The neurotic's belief in the unique and exceptional nature of his illness is a universal clinical observation. Over and over again the neurotic patient reminds us that his Christlike tortures are beyond the physician's comprehension. The typical lamentation of such a patient—"If you only knew what I feel in a single moment!" as if his only wish were that some other person might experience equal pain — echoes throughout *The Locomotive God.* The book is a pathetic cry for help and at the same time an incessant assurance that it will not be forthcoming. The author confesses that it was undertaken "partly as a last experiment in cure".

I perfectly agree with the author that "he knows more intimately than Freud the meaning of 'Know thyself' "—if by this the author means the unceasing sensations of fear and compulsion. Such "self-understanding" is certainly "different from that of poets and psychoanalysts", as the author points out.

Throughout the presentation of his case, the author seems to suffer from a painful compulsion to defend himself against supposedly disinterested listeners and to protect himself from hostile surroundings. The circle of reproach includes persons with whom he comes into contact, and above all himself, self-pity thus accentuating pain. No other human being can feel nightmares "in the sleeps of my clinic". His anguish reminds one of the pleasurable suffering derived from provoking pain in a diseased organ.

One may ask whether it is fair to criticize a sufferer who calls for aid. The psychopathologist would be the last person to do so. However, to the healthy—or at least the non-neurotic—reader, it must be said that Professor Leonard is not competent, because of his illness, to serve as judge or to take the witness stand against psychoanalysis with its limitations *as he understands them*. The reader must instead be warned against accepting such phrases as "the subconscious mind" or "the imagination or, rather, subconscious memory" as being more than literary mannerisms. Such reflections as *"My phobia has not even served to avenge me on my enemies"*, might be mistaken for far-reaching self-analysis. But since the author does not present to the reader even a part of his *unconscious* cravings, such as we are accustomed to bring to light through a technical psychoanalytical study of cases of agoraphobia or compulsion neurosis, we fear that the aspects formulated are arbitrary ones, unfounded and, furthermore, not credited by the author himself.

The material presented is flimsy, the insight into the psyche shallow, because we get little of the real events between the advent of the "Locomotive God", when the author was two years old, and the onset of the phobia some fifteen years ago. It would not be wise to formulate hypotheses that are not yet supported by findings in the field of the unconscious.

The author's self-indulgence and intense self-admiration, the kind of shrine of pain that he has erected and before which he now worships — securing the phobia against a change — constitute what is technically called "resistance against cure". (It might be well to mention that technical analytic sessions of even a few hours usually bring out more of the actual workings of the mind and present a more varied aspect than the rigid, set, *mono-dimensional* descriptions that have engaged the author's careful study.)

The exclusion of *material of the unconscious* prevents us from calling the book self-analysis at best. The author not only fails to understand the significance of unconscious experiences in reference to parents, relatives, and friends, of the thousands of incidents in his everyday life, of his habits, of his dreams and, above all, of his sex life—its development from infancy to manhood, and so forth—but completely ignores them.

Whether or not psychoanalysis—a systematic technical cure, not casual chats!—would be successful in this case cannot be determined from reading the book. The author's statement, however, that cure of his exceptional case would be a "final demonstration of the powers of psychoanalysis" is, to say the least, a debatable question.

Since the readers of this review are interested primarily in the psychopathological aspects of the book and since I do not presume to evaluate its literary qualities, just a word as to them will suffice. The monotonous egocentric mood of the phobic author makes the book difficult and morose reading. Beauty of language and stylistic values are lost. His descriptions of new surroundings and foreign countries fail to cause the reader to breathe fresh air, fail to conjure up for him a picture, alive and fresh, of France or Switzerland, but heavily force upon him the suggestion that the author is reminiscing at his desk in a Middle-Western town. When, in describing the beauties of nature, he speaks of "angels and fairies in sportlike fancy", he seems to summon them in his dejection and helpless searching for protection—as a kind of medication rather than the gay creatures of a healthy imagination.

Professor Leonard would quickly regain the confidence of his many admirers, whom he has so delighted with his previous poetic creations, if he were to endulge his creative talent once more. In the absence of a radical cure, he might perhaps gain more relief from this than from self-torturing pseudo-analytic introspection.

Dorian Feibenbaum.

New York Psychoanalytic Society.

Great Teachers and Mental Health; A Study of Seven Educational Hygienists. By William H. Burnham. New York: D. Appleton and Company, 1926. 351 p.

In stating the purpose of this book, Dr. Burnham says: "It is obvious that nothing can be more helpful to the younger teacher and the student of education than to study the great leaders of great educational movements." Following out this idea, he gives a sketch of the lives and works of Socrates, Jesus, Roger Bacon, Vittorino, Trotzendorf, Comenius, and G. Stanley Hall. That he presents them

as inspirations to activity on the part of the developing educator, not merely as authorities whose theories should be known, is to be assumed from the fact that he relates their work to present-day problems. He concludes the book by calling special attention to the rôle of democratic and aristocratic ideals in education and to the form in which these ideals may aid and be aided by the teacher. His ideal is a combination whereby every pupil may be developed especially along those lines in which he can make his greatest contribution.

Dr. Burnham rightly claims for the school the most strategic position next to the home in the furthering of healthy mental development, and his final discussion should be read by any teacher who doubts her responsibility for the mental health of the child. Dr. Burnham's hope is that this responsibility may be the means by which the conception so frequently held by teachers at present of their work as just a job may evolve into a professional concept even more potent than that of the past. He sees a practical identity between the aims of sound education and the expressed purposes of the mental-hygiene movement. In the great teachers of the past whom he calls on to help develop his theme he sees various of the principles of mental hygiene unusually well worked out in this or that case, although in some other respects these teachers were sufficiently unhygienic. In Socrates he sees the exponent of fearlessness of fact and the attainment of maturity by learning rather than by being taught. For this, a realization of one's own ignorance is essential before real learning can begin, and application, work, or practice, not knowledge only, are necessary for increased acquisition and integration. The stumblingblocks in the path of this ideal were set forth by Roger Bacon as authority, custom, common sense, and pretense of wisdom. The author adds a fifth source of error, slavery to machinery—specifically here educational machinery.

In this university invisible which Dr. Burnham has revealed, the faculty of education is a prominent body. It overlaps with other faculties. Outstanding on this faculty, if not its dean, is G. Stanley Hall. Much of the book is devoted to Dr. Hall's contributions and to his modernization and practical application of the contributions of his predecessors. His eight tests of character—health, constructive enthusiasm, response to pleasure and pain, sympathy, love of nature, sublimation, activity, and loyalty—are founded upon human characteristics whose consideration and proper unfolding are essential to mental health.

Terms such as "mental-hygiene principles" frequently confuse the uninitiated because they are not presented in codified form and are so often understood only in relation to a specific situation. The

great teachers here discussed provide these specific situations and at the same time, without codifying, make the general principles stand out. If one sets aside the demand for a one-two-three formulation of these principles and allows oneself to become interested in the men that Dr. Burnham introduces, one will unwittingly gain the principles that one is searching for.

GEORGE S. STEVENSON.

The National Committee for Mental Hygiene.

THE NERVOUS CHILD AND HIS PARENTS. By Frank Howard Richardson, M.D. New York: G. P. Putnam's Sons, 1928. 400 p.

The reviewer finished this book with mixed feelings. In general he felt that the various problems presented by children were skillfully and entertainingly discussed, and that the pleasant, rather naïve style would make a broad appeal to parents, who, deeply interested though they are in their children, have neither the time nor the energy to read the usual scientific volumes on child training. He could hear the average reader remarking with satisfaction, at the end of the last chapter, "There's a man with some common sense."

These very elements of popular appeal make one wish that parts of the book were either different or deleted entirely. In the first place, although the author clearly has considerable insight into child psychology, he tends to stress unduly the importance of physical factors. Furthermore, through the use of such terms as "nerve force", "nerve stamina", "nervous susceptibility", he perpetuates the misconception that, resident somehow in the nerve cell, there is a definite, measurable quantum of energy which can be depleted or restored like the electrical charge of a storage battery. While the bland acceptance of this theory permits him to simplify his explanations to the point of easy comprehension, one hopes that in subsequent editions he may keep the same simplicity, yet refrain from employing terms that, although they convey to the uninitiated the impression of scientific authority, really help to maintain a false notion of mental life.

A second criticism is that the book has indications of having been hastily written. Otherwise the use of the quotation on masturbation on pages 151 and 152, when the preceding pages expressed entirely different ideas, is difficult to explain. The chapters in Part III particularly give evidence of being a series of concepts, valuable in themselves, but with no well-worked-out relationship to one another.

The book has five parts. Part I—under the heading, *What Is the Nervous Child?*—emphasizes sensitivity to the stimuli of his environ-

ment as the principal characteristic of the "nervous child", a fairly practical and useful concept.

Part II—*What Does the Nervous Child Do?*—discusses the immediately precipitating factors in the production of behavior. Various problem traits are described, their basis in child psychology is pointed out, and some practical measures for handling are offered. The chapters on temper tantrums, jealousy, refusal to eat, and disobedience are adequate, although the advice on page 169 in favor of a five-meal-a-day-régime, based apparently upon the old bogey of malnutrition, is open to question. In the chapter on quarrelsomeness, the problem of teasing and bullying is dismissed with scant attention in one brief paragraph, despite the fact that it generally lies at the root of most quarreling. The discussions on sleep disturbances and speech disturbances are satisfactory. Inclusion of the recent work of Orton would be a valuable addition to the paragraphs on handedness found under speech disturbances.

With regard to bed-wetting, thumb-sucking, and nail-biting, the author manifests a strange and certainly unnecessary warmth when he refers to them as "vicious", "abnormal", "vicious addictions". Since the problem of masturbation is treated in a nicely objective manner, this attitude toward the other habits seems all the more surprising. As to the treatment of bed-wetting, the omission of the advice to wake the child thoroughly at night on taking him to the toilet is a serious oversight, since the aim should be to get the child on his own responsibility to wake himself at the proper time.

Regarding "regression" or infantilism, "compulsions", and "habit spasms", the author gives a brief explanation and some sound and helpful suggestions as to the attitudes to be taken toward these manifestations. This part ends with chapters on lying, stealing, and running away. Despite all current findings in the study of crime, the old correlation between low intelligence and crime is maintained. Also, in discussing the causes of stealing, no mention is made of mental conflict or of the so-called splurge type of stealing in which the child takes money in order that, by treating the gang, he may gain the good graces of his fellows.

Part III—*What Causes the Nervous Child?*—is a consideration of background factors and includes discussions on the rôles of parents, nurses, teachers and schools, heredity, malnutrition, and adolescence. The field to be covered is entirely too broad to be adequately treated, but the material given is sane and worth reading.

Part IV—*What the Nervous Child May Be*—takes up the constitutionally inferior child. Since the existence of such a condition is still questionable, mention of it in a book for parents is unwise and

should be omitted. Part V also seems out of keeping with the rest of the book. Its efforts to tell "what the nervous child is not" has caused the author to cram into a few pages discussions on mental retardation and the major psychoses. All it will do is to set up bugaboos for parents to worry about, and they surely need no more than they already have.

After these criticisms, it may seem strange that the reviewer can still say that he likes the book. He does, and feels that it will fill a useful place in the literature for parents. Its good points considerably overbalance its bad. It does picture the child as a human being without being sentimental about him, and it does, through its stress on causality, help to do away with the concept that children are innately bad—or, for that matter, innately good.

A word should be said about the illustrations, which are in black and white. They are apt and clever and add distinction to the book.

HARRY M. TIEBOUT.

Institute for Child Guidance, New York City.

THE NEUROTIC PERSONALITY. By R. G. Gordon, M.D. New York: Harcourt, Brace, and Company, 1927. 300 p.

The scope of this work is comprehensive. It discusses in order the "construction of personality" in general; the failures of adaptation of personality that result in the various types of neuroses; present-day points of view in psychopathology as influenced by Janet, Freud, Jung, McDougall, Rivers, and others; and, finally, the scope and limitations of the various methods of psychotherapy.

Dr. Gordon, as he states in his preface, approaches his subject with a background of study and interest in its physiological and psychological aspects. The philosophical side of human life he leaves to other hands. On the whole, it is the psychological aspects of personality and neurosis that most concern him, although throughout he endeavors to correlate psychology with some organic substratum. Cortical functioning, engram patterns, endocrine physiology, and the contrast of cerebro-spinal and autonomic nervous activity are freely called on to explain psychological states. At the present stage of scientific knowledge, it seems that this commendable attempt to bring together psychic and cerebral activity results rather in the complication of theory than in the elucidation of fact. However, it has at least the virtue of preventing a one-sided view and avoiding any need for a dualistic concept. In these days of the supremacy of psychogenesis, a reminder of the fundamental unity of body and mind is not amiss.

With the exception of this tendency to drag in by the heels some rather heavily conceived organic pathology, the author shows unusual

freedom from bias or prejudice, and appears to have the rare faculty of grasping the point of view of those with whom he does not wholly agree.

As to the construction of personality, the doctrine of *emergent evolution* appeals to Dr. Gordon as the most pragmatic theory. This doctrine (page 7) "lays it down that when simpler substances combine under certain relationships with the environment, the resulting substance is something unique, which enjoys a quality of its own. This proposition may be applied in both the organic and inorganic realms to matter, life, and mind." On the same page he quotes Lloyd Morgan as follows: "The orderly sequence of evolution historically reviewed appears to present from time to time something genuinely new. Salient examples are afforded in the advent of life, in the advent of mind, and in the advent of reflective thought."

With reference to the neurotic, the following quotation (pages 26–27) sets forth the author's views. "The doctrine which he [McDougall] puts in the forefront of his psychology is the dominance of the personality by the self-regarding sentiment which acts as the keystone of the arch, enabling the individual to find contact both with himself and his environment. In my opinion the close study of neurosis cannot but confirm the importance of McDougall's contribution in this respect, for whatever may be the underlying difficulty which leads to neurotic illness, it is the failure of integration within the self-regarding sentiment which is the characteristic mental lesion, if we may be allowed the expression, and it is to the restoration of this integration that we have to direct our therapeutic efforts. . . . If we try to describe the neurotic personality in terms of this definition, we would say that the plan on which he is organized—that is, his philosophy of life—is unsatisfactory, and his higher organization—that is, his self-regarding sentiment—is incomplete."

In discussing the Freudian concept of mental conflict within the personality, the author states: "Freud deserves the very fullest credit and universal acknowledgment for being the first to point this out. . . . Freud approached the subject purely from the psychological standpoint, and though he admitted that conflict and repression might be explicable in terms of physiology, he made no attempt to work this out. Since our conception of personality has been built up on physiological principles, it seems to be worth while to try to translate Freud's purely psychological concepts into physiological terms."

Dr. Gordon sums up the problem of the neurotic as follows (page 49): "The neurotic personality, then, is a personality who, owing to the circumstances of life in which he finds himself, is subjected to

conflict between two patterns within his self-regarding sentiment, neither of which can gain the ascendancy and suppress the other, nor can they become integrated and so fuse with one another. Consequently they more or less cancel each other out, though activity may spread through associated sub-patterns, giving rise to a symbolic representation of their conative form, or through vegetative sub-patterns, causing visceral manifestations and affective experiences of a more or less distressing type. Or, on the other hand, some part of the personality may become split off, so that it can find no contact with the rest and so becomes dissociated. So we find that the two most important processes in neurosis are dissociation and repression. They are both methods of resolving or attempting to resolve conflict, and although not mutually exclusive, tend to occur in different types of personality. It is of some interest to note that all authorities do not pay equal attention to the two processes; for example, Janet has given his interest almost exclusively to dissociation, neglecting repression, while Freud concerns himself almost entirely with repression, only mentioning dissociation to pass it by without discussion."

The greater part of the book—about two-thirds of it—is given over to a description of the various types of nervous disorders and methods of treatment. Sufficient case material is presented, chiefly from the war neuroses. The author objects to what he considers the pan-sexualism of Freud, and borrows freely from all sources, but in spite of this it is clear that the main influence on his own work has been psychoanalytic doctrine. The modification of Freudian psychology developed by Jung is sympathetically presented. Dr. Gordon grasps the principles of psychoanalytic treatment with rare insight for a nonconformist, and endorses it for selected cases.

As a review of the present status of psychopathology and psychotherapy, the book is to be highly endorsed. It is written in simple enough language to have value for the non-medical reader. If read with certain reservations, there is no one book that will better orient the student in regard to the problem of the neuroses.

MARTIN W. PECK.

Boston Psychopathic Hospital.

THE CRIMINAL AND HIS ALLIES. By Marcus Kavanagh. Indianapolis: Bobbs-Merrill Company, 1928. 433 p.

This is a book by the judge of the Superior Court of Cook County, Illinois, whose conduct of one case was described by the Supreme Court of Illinois as "unfair" and "incompetent" and "prejudiced", laying his "good faith open to question". (326 Illinois, pages 341–54.) The case that brought about these many pages of criticism and denunciation of Judge Kavanagh was one that involved a dis-

cussion of the mental condition of a criminal. When the prejudices of a judge result in such unfair and prejudicial conduct of a case and its cross-examination that the Supreme Court quotes the dialogue and devotes about ten pages to such criticisms as those cited, it is safe to assume that the unfairness is flagrant.

This is the kind of book that one would expect such a judge to write upon such a subject. It is full of bombastic and hortatory passages, crowded with misstatements, and replete with elaborate quotations from the judge's past efforts at eloquence, bristling with such adjectives as "sensual", "reptilian", "wicked", "brutish", "indecent", "terrible", "degraded", "unclean", and so forth.

The book is scarcely worth taking seriously. There are, however, a few valuable portions. The author is justifiably concerned with the fact that so few offenders are apprehended and that so many are released without the detention that their offenses indicate as desirable. He puts the blame for this largely on the shoulders of the lawyers.

Another commendable portion of the book is the discussion of the parole system. The author calls it a tragic commentary upon the inefficiency of the American power of jury "that the two latest and mightiest instruments for the uplift of the fallen and the protection of the innocent . . . should be turned by sentimentalists into forces which help to an appalling extent in the creation of recidivism. . . ." He refers to the parole and probation laws. An excellent paragraph on page 346 is followed by an absurd paragraph on page 347 in which he advocates, as a basis for paroles, "true penitence". This again is followed by some excellent paragraphs in which the bad effects of prisons are described, and these in turn by another batch of absurdities about instilling in prisoners fear of the law, love of its beneficence, and so forth. The author makes some sensible remarks about the laws prohibiting the sale of revolvers, and describes graphically the painful duties of the judge in pronouncing sentence. He has something to say about the mental equipment of criminals and on the subject of spiritual values. In this connection he calls the ministers to account for their failing popularity and explains it to them.

The author's attitude toward psychiatrists and the psychiatric aspects of crime is a mixture of ignorance, prejudice, and asinine bombast. He quotes Adler, Healy, and others in curious detached and distorted ways as if to prove by such quotations that psychiatrists in general know nothing. He seriously maintains that in the cases of Lombroso innocent individuals were sent to prison "mostly because of the size of their ears", and that psychiatrists are now going to send people to prison on the basis of equally misleading "tests". He goes so far as to say that some psychopathic laboratories in this

country would find 50 per cent of the readers of this book mentally unfit and dangerous to have at large.

Of course Judge Kavanagh feels that what we need besides better laws is a widespread and unflagging demonstration of hard-boiledness. Flourishes of sadistic glory, even to the point of strong advocacy of the whipping post, enliven the pages. The death penalty comes in for some ballyhoo, and Mr. Pinkerton is quoted as a good authority to substantiate the author's ideas of "what to do with 'em" when they are caught.

The book has all the virtues and all the faults of an emotionally determined, moralistic, bombastic, but earnest reformer's cry. If the judge were better informed, if he were not quite so fond of quoting his own experiences, if he would delete his attacks on lawyers, ministers, psychiatrists, policemen—in fact, every one except judges—the book would shrink in size about 65 per cent and increase proportionably in value.

KARL A. MENNINGER.

Topeka, Kansas.

BETTER DOCTORING—LESS DEPENDENCY. By Louise Stevens Bryant. New York: Committee on Dispensary Development, 1927. 90 p.

This study is an effort to understand some of the differences that make for misunderstanding, lack of coöperation, and inefficiency in work carried on jointly between out-patient clinics and family social-service agencies. It attempts formulations and experiments to reduce these problems of coöperation. Many of the points discussed are significant for all coöperative work between medical and social-service organizations; others are of importance in their bearing upon the efficient work within these agencies, on cases that do not involve coöperation. However, the high percentage of conditions that call for medical treatment in dependent cases makes smooth, efficient coöperation imperative. In half the cases of social dependency, medical problems are assigned a major rôle. The waste, financial and otherwise, in meeting this medical need is enormous.

Whether this estimate places too much or too little of the blame for dependency upon medical problems, one can hardly say. Within a single agency the variations from year to year in the causes to which dependency is attributed are so wide as to make one cautious about accepting the latest estimate. Furthermore, the extent to which the psychological aspects of dependency are conceived of as medical would tend in some cases considerably to reduce the rôle attributed to medical conditions, in others greatly to expand it. For example, drug addiction and alcoholism are here considered problems for the neurologist

and the alienist, although other, less chemical means of attaining the same satisfactions are not so considered. However, at that, the progress that is evident in the fact that dependency is regarded as the result of a cause is gratifying, even if it is responsible for a problem in coöperation. The danger lies in looking for *a cause* rather than *for causes.*

For meeting these problems, some agencies have established facilities of their own, but the majority have to depend on existing medical clinics. There are differences in points of view that make it difficult sometimes for the medical clinic to give the social agency just what it wants. More usable data are needed, and greater conservation of the time of the physician and the social worker. Much time is lost in the process of getting a client examined; much also through the failure of the effort to produce results. The client patient requires more of the time of the physician because of the more general, less emergent nature of his medical problem. The whole problem of privileged information, correlation of medical facts by non-medical workers, and more or less compulsory submission to the examination, enters into the attitude of the clinic.

In dealing with these problems, we stand in most instances on virgin soil. The only safe approach is the experimental approach. On this basis the use of a medical social worker as an intermediary between clinic and agency and the use of forms designed to eliminate the differences were undertaken. A two-year experience with these showed that they did not solve the problem, although they did reveal, in an objective way, previously described points of weakness and in some cases were considered a process to be continued.

Certain general conclusions are evident from the study:

1. Social agencies often fail to define the problem upon which information is desired from the medical agencies.

2. Social-service departments in many instances do not, are not able to, carry the work put upon them by the agencies.

3. Behind these evident difficulties lie questions of functional distinction between the medical and the social agencies which should be clarified by some systematic process of discussion and analysis.

4. The successful use of the consent form on the steering and reference blanks demonstrated that one source of difficulty in obtaining certain medical information by the social agencies may ordinarily be removed.

5. It is evident that conditions in the numerous hospitals and clinics and in various social agencies differ too widely, and that the underlying problems are too deep-seated, to permit of any one simple solution to

the whole situation, or of any solution through a merely mechanical means, such as steering blanks or other record forms.

These conclusions show the present status of the relationship between the out-patient clinic and the social-work agency. The recommendations presented are the logical steps by which we should advance from where we are to where—according to the most advanced, even if not the most usual—social opinion we should wish to go.

GEORGE S. STEVENSON.

The National Committee for Mental Hygiene.

DIRECTING MENTAL ENERGY. By Francis Aveling. New York: George H. Doran Company, 1927. 276 p.

It is somewhat difficult to review this book, because it is not entirely apparent what purpose the author had in mind. There seems to be no reason for believing that it is intended for the scientifically trained reader, nor does it fall into the category of those writings which are planned to educate the lay reader in the principles of physical or mental hygiene. One is forced to conclude that it is the offspring of an irregular union between science and journalism, falling, like most hybrids, into neither of the parent classes. To put it more simply, this seems to be one of those books for which a fashion probably was set by the commercial success of *Why We Behave Like Human Beings*. At least, this is the only explanation that seems logical to the present reviewer.

Dr. Aveling devotes his first two chapters to a discussion of the loss of human energy through unnecessary waste, proving the need of a more economical attitude. His following chapters, he claims, are designed to show the reader how to conserve physical and mental energy and to avoid this waste. As a matter of fact, the rest of the book is simply a collection of facts in regard to certain psychological topics—industrial psychology, fatigue, memory, mental tests, vocational guidance, emotions, will, and character. Here and there, to be sure, are suggestions as to the applications that the reader may make to his own life, but we venture to predict that the lay person will close the book without having acquired any systematic knowledge of health or energy conservation.

While for the most part there is no reason to disagree with the author's statements from a scientific point of view, this is not invariably true. For instance, no clinician, whether psychiatrist or psychologist, could agree unreservedly with the statement on page 178: "It is quite possible, for example, to change a depressed emotional state into one of elation by merely altering the general posture of the body." Moreover, the journalistic style sometimes leads the author

into inconsistencies; witness the contrasting uses of the term "will" on pages 62 and 187. In the first instance, the impression is given that the will is mental energy; in the second we are definitely told that there is no evidence of this. But if Dr. Aveling's attempt to combine journalism and science leads him into no greater difficulties than this, perhaps we can forgive him.

Whether we can, depends, of course, upon our feeling in regard to books of this type. The present reviewer has not attempted to conceal a very critical attitude. This book does not give us any new truth, nor does it say an old truth more beautifully or usefully than before; therefore, one cannot praise it with a clear conscience. Its appeal will be to minds of the type of Hermione and her little group of serious thinkers, who will exclaim (if Don Marquis will permit the plagiarism): "Isn't *mental energy* wonderful? How could I ever have lived so long without it?"

PHYLLIS BLANCHARD.

Philadelphia Child Guidance Clinic.

POPULATION PROBLEMS IN THE UNITED STATES AND CANADA. Edited by Louis I. Dublin. Boston: Houghton Mifflin Company, 1926. 318 p.

The American Statistical Association, under the stimulus of its president, Dr. Dublin, gave special consideration to population problems at its annual meeting in December, 1924. The present volume is an outgrowth of the papers presented at that meeting.

The opening chapter, written by Dr. Dublin himself, sets forth various phases of the population problem and outlines the scope and purpose of the book. Dr. Dublin points out that the problem has two main aspects—the one quantitative and the other qualitative. The first includes the facts as to composition and movement of population and involves the question of future growth and consideration of the various factors relating thereto, such as agricultural and mineral resources. The qualitative aspect deals with racial characteristics of the population, contributions of the various stocks, and policies in regard to shaping the future composition of the population. Other factors not classifiable under either of these two heads relate to standards of living, labor problems, the efficient management of resources, and similar problems.

The book also discusses the ideals that should control in determining our population problems, and sets forth a program which, if followed, would bring us nearly to the desired goal.

The editor discusses the decline of the birth rate, which seems to be most marked in the upper strata of society. His attitude toward

the problem is well summed up in the following words: "The editor expresses his faith in the common people and their potentialities. . . . We see on all sides clear evidence of the ability of ordinary people to give birth to children capable of the highest achievement as opportunity and environment release their power." He further states: "There has always been a differential birth rate and a replacement of one group of people above by another, equally good, from below. In all ages, men have raised themselves above their inherited station in life and have occupied the seats of the mighty, left vacant by those considered their superiors, who have neglected or have not been capable of performing their highest obligation to society, namely, parenthood. In all fairness, we must critically examine the current point of view and shift the emphasis in our population discussion from a glorification of the upper strata to a more generous recognition of the inherent worth of the great mass of mankind."

The second part of the book contains articles on population growth in the United States, the natural increase of population, and urbanization of population. The first of the three papers, by Professor Reuter of the University of Iowa, reviews the increase of the white and Negro population of the country as shown by the Federal censuses from 1790 to 1920. He finds that during the nineteenth century the native Negro stock in the United States increased 663.3 per cent, while the native white stock increased 693.3 per cent. After reviewing the various factors relating to the increase of population, he reaches the conclusion that prediction relating to population increase, even in the immediate future, is an extra-hazardous type of speculation.

In discussing the natural increase of population, Professor Warren S. Thompson reaches the conclusion that the rate of natural increase in this country is probably as great as can be well taken care of under the economic conditions that now exist, and it seems doubtful whether we can support such a rate of increase for many decades. There are indications, however, that our annual increase is on the decline, so that it probably will not outrun the possibility of maintaining or improving conditions of living for half or three-quarters of a century, provided immigration is not too great. He further holds that much of the improvement in living conditions has been achieved at the expense of the size of the family. With respect to the differential birth rate, he agrees with Dr. Dublin that the dying out of certain upper and middle-class groups in our population is not a very serious matter. He makes a plea for an earnest study of our present urban industrial civilization to determine whether family life can be given a proper place in it. In closing his valuable paper he uses these words: "The history of civilization shows us that man is the product

of rural conditions of life. Like Antæus, he seems to retain virility only when he is in contact with Mother Earth. Can we change his nature? Or can we more easily adapt our civilization to give man his needs? Here is a problem which should challenge man's best efforts."

Part III, which deals with population and natural resources, is made up of the following papers: *The Optimum Size of Population, Population and Agriculture,* and *Mineral Resources for Future Populations.* The writers of these papers look forward with apprehension to a time when the population will outrun the food supply, the coal and oil resources will be exhausted, and the supply of lumber, paper, and fibers will be entirely inadequate to supply the needs of the people. Reference is made to the possibility of finding substitutes, but no adequate sources of new energy supply can be predicted from present knowledge.

Part IV, which deals with population and immigration, contains an interesting discussion by Ales Hrdlicka upon the development of the American type of man. He holds that the white people of America have approached the formation of such a type, which he describes as follows: "This type is a good one. It is characterized by tall stature, being the tallest of all the larger groups of white people; by, on the average, a medium pigmentation of the hair, with scarcity of adult blonds and near-absence of blacks; by prevalently mixed eyes, or light ones showing more or less of a brown admixture; by an inclination, especially in youth, to sinewy slenderness; and by other features. The main characteristics of its behavior are, in general, frankness, openness yet shrewdness, energy, and persistence, with, in general, but little sentimentality or affectation, and relatively few extremes except perhaps in industrial, financial, and occasionally in religious endeavors."

Another paper of merit in this part of the book is *Immigration and National Life,* by Alexander Goldenweiser. After setting forth the contributions made by various immigrant peoples to American life, the author makes the following significant statement: "Current Americanization theory is based on a belief in the desirability of cultural uniformity. This belief is not warranted by history. Cultural diversity, the coming together of different outlooks and traditions, the juxtaposition of different standards, have always fostered greater objectivity, a liberal attitude toward men and things, a toleration of standards and habits other than our own, and greater cultural vitality and creativeness."

In the section which deals with the outlook for the future, Professor Samuel J. Holmes discusses the effect of the health movement on the

welfare of the population. He raises many interesting questions relative to the selective effect of various diseases, but does not answer them.

The book as a whole is a remarkable symposium on a subject of first importance and should be read by all students of society and by all who have a part in shaping our governmental policies with respect to health work, immigration, labor, and domestic relations.

HORATIO M. POLLOCK.

New York State Department of Mental Hygiene.

THE PSYCHOLOGY OF YOUTH. By Edgar James Swift. A new edition of *Youth and the Race.* New York: Charles Scribner's Sons, 1927. 342 p.

This author assumes, as an explanation of child play, the recapitulation theory, according to which children in their games tend to re-enact the history of the race and the behavior of their ancestors. Much of the undesirable behavior of children is traced to a lack of understanding of children's natural tendencies to express themselves and to attempts made by society to dam back or to direct wrongly the natural expression of children, especially along emotional lines. The author is very generous in the examples given to emphasize the chief points as they are mentioned.

The necessity for normal expression is stressed, and ways are suggested for accomplishing it through such organizations as the Boy Scouts, student-government bodies, and other like groups, where the children formulate and obey their own rules instead of being hemmed in by what are to them the arbitrary and unnecessary rules of grown-ups. The necessity of appealing to their natural tendencies or instincts is emphasized as well as the importance of placing responsibility on them to this end.

The school system comes in for a great deal of comment, and the author emphasizes that most children in their school training do not receive the individualized guidance each requires to prepare him for life. Statistics are freely quoted which would tend to show that a large percentage of children are not being actually prepared for life, that our present school system is too rigid and almost entirely ignores individual needs. It is also shown that many children are almost forced into lives of delinquency because of the unintelligent way they are handled in the schools. The necessity is pointed out of bringing the community and the school closer together by making the schools social centers in order that they may contribute more than they have been contributing to the social and educational development of their respective communities.

Stress is placed upon the value of the "group instinct" which can and should be capitalized by educational forces for good purposes in order to develop a more practical expression of the social and racial elements in the child.

The chief thesis of the book is the need of individualization in child training by taking into consideration the specific needs of different children and of children in various periods of growth. Many stories and case facts which appeared in publications about the year 1910 are cited to clarify the various principles of behavior that are developed by the author.

The book should prove both interesting and profitable to those concerned in the study of and the care and training of children.

Frank J. O'Brien.

Louisville Mental Hygiene Clinic.

Mind and Its Disorders: A Textbook for Students and Practitioners of Medicine. By W. H. B. Stoddard, M.D. Fifth Edition. Philadelphia: P. Blakiston's Son and Company, 1926. 593 p.

This textbook of psychiatry has gone through five editions since 1908. It is almost encyclopedic in its scope, and reflects fairly well the recent advances in psychiatry. The author shows by his treatment of the subject that he has become a loyal disciple of Freud; the thread of psychoanalysis runs through the entire book.

Eleven chapters are devoted to normal psychology. "Sensation psychology", as well as "wish psychology", is very thoroughly discussed, and there is a chapter on the development of the ego and the super-ego.

There are eight chapters on the psychology of the insane. Disorders of perception, emotion, and conduct are not only described, but their genesis is explained. Delusions and anomalies of the sex instinct are likewise dealt with. There is a chapter on psychoanalysis, explaining the theory and principles of treatment quite clearly, but all too briefly as far as the technique is concerned. The author is silent on such topics as recognizing and handling resistances, dream analysis, and modes of terminating treatment.

Twenty-two chapters are devoted to the psychoses and neuroses. They are very thoroughly covered, but the author still clings to the older nosology and ignores the classification of mental diseases adopted several years ago by the American Psychiatric Association, so that the tyro psychiatrist on this side of the Atlantic is apt to be confused and led astray by such statements as: "Senile melancholia should be re-

garded as the depressed stage of maniacal depression", and: "One severe case of senile melancholia recovered after three years." No sharp demarcation is made between the arteriosclerotic and the senile psychosis, as in the American classification; they are both grouped under the heading of "chronic cortical atrophy". There is a chapter on mental deficiency, but here also the older terms are used—*e.g.*, "semi-imbecile" in place of "moron" and "moron imbecility" for "psychopathic personality". In a chapter on combined psychosis, the author mentions manic-depressive and dementia praecox with admixture of exhaustive symptoms. But he fails to discuss the much more pertinent question of schizoid manics or manic schizoids, *à la* G. H. Kirby and Adolph Meyer.

Because of the difference in terminology and the inclusion in the book of a number of dogmatic statements which are still regarded as highly theoretical probabilities by most authorities, the reviewer is of the opinion that it is not the best book to recommend to the American beginner in psychiatry. The chapter on case taking is rather skimpy and does not offer any outline for the study of the mental make-up of the patient prior to the development of the psychosis. Occupational therapy is treated perhaps too briefly. Recreation is assigned but two or three lines, and physical culture is not mentioned at all. Nothing is said about out-patient or dispensary work, or the after-care or home-parole system; nor is psychiatric social service mentioned.

The book has many features in its favor, however, which far outweigh its few faults. The author treats fully many practical phases of psychiatry that are more or less neglected in most textbooks. There is a monthly summary of the development of mentality from infancy through the second year. The treatment of insomnia is exceptionally well covered. In fact, throughout the work the sections devoted to treatment are more generous than in most textbooks. Prognoses are discussed in detail. There is a page on the physician's attitude toward the patient that should occupy a prominent place in every textbook on psychiatry. The book includes chapters on feigned insanity, the law and insanity, staining of nervous tissue, examination of spinal fluid, and so forth.

As a companion to one of the more elementary American textbooks, it is well worthy of a place among the everyday reference works of the extramural or intramural psychiatrist.

H. L. Levin.

Buffalo State Hospital.

HANDBOOK FOR THE MEDICAL SOLDIER. By Arnold Tuttle, M.D. New York: William Wood and Company, 1927. 691 p.

In the foreword of this book, Surgeon-General Ireland outlines the varied experience of the author that well qualified him to write the successor to Mason's handbook, long used as the foundation for the instruction of enlisted men. General Ireland endorses this book, upon which will be based the questions used in competitive examinations such as are held from time to time for the appointment of non-commissioned officers in the medical service of the regular army. In short, as the author states, the intention of the book is to furnish the fundamental knowledge needed by enlisted men in their study for promotion and by instructors in conducting classes for them.

Brief extracts from the Declaration of Independence and the Constitution, outlines of the growth of the nation, the organization of the government, the meaning of the flag, and so on, give the enlisted man a fitting introduction to the study of his responsibilities as a medical soldier. This is followed by accounts of the organization of the army as a whole, of the history and organization of the medical department, the medical aspects of mobilization, the medical service in the field, rules of warfare, military courtesies and customs, military law, and army and training regulations. Some of this is highly technical and obviously beyond the scope of the ordinary enlisted man. As the author indicates in the preface, however, it is necessary for the non-commissioned officers to know such matters, especially as some of them in time of war temporarily act in the higher grades in the so-called "key" positions.

Anatomy, physiology, materia medica, and pharmacy are briefly, but sufficiently covered. In the chapter on hygiene and sanitation, special attention is paid to the purification of water, the ventilation of barracks, disposal of wastes, and personal hygiene.

Chapters are devoted to first aid, of obvious importance to the medical personnel of an army; nursing, a knowledge of which is essential, although in many situations the enlisted man will be associated with the members of the army nurse corps; minor surgery; mess management, foods, and cooking; public property, the care of and accounting for which often distresses both officers and men; clerical work, for records must be kept in spite of the cry against the increasing paper work; the administration of military hospitals; the care and operation of motor vehicles; and the care, riding, and driving of animals, for even in this motorized era, dependence must still be placed upon transportation by animals in some situations. Useful tables are included in a chapter on mathematical principles.

Several alphabetical lists of terms with brief definitions are scat-

tered through the book and there is a comprehensive general index. The book is well bound with a semi-flexible leather cover. Some of the charts are difficult to decipher because of the microscopic lettering and blurring of the print. In general, however, the book embodies in concise and readily accessible form much of the information essential to the medical soldier, and it will not unduly add to the impedimenta.

But in spite of the general excellence of the handbook, at least one important consideration in military medicine has been almost wholly neglected. Aside from a few definitions and minor references, the mental aspect of the soldier has been almost ignored, a surprising situation in view of World War experiences. A neuropsychiatrist is listed with other consultants in field service; the terms neuropsychiatry, delusion, dementia, illusion, hallucination, psychosis, shell shock, and restraint are briefly defined; and in a discussion of symptoms in the chapter on nursing, there is a short paragraph on the disorders of consciousness. There is, however, no well-formulated presentation of mental medicine or nursing.

Certainly the enlisted man might profit by some acquaintance with the principles of mental hygiene, at least from the point of view of so-called "morale". A knowledge of some of the outstanding facts of mental deficiency and mental disease would help the recruiting detail to eliminate at the source some of the undesirable material. Psychoneurotic and psychotic individuals complicate the problems of the medical field service and hospital administration both at the front and in the interior. In the early days of the World War, there was considerable difficulty in establishing the needs of mental patients in respect to proper housing, nursing, and treatment facilities. It would seem logical that such a handbook should contain the lessons of past experience as to safeguarding the welfare of mental patients in the army, or, from the other standpoint, protecting the army from the complications resulting from the presence of mental disorder and defect. To judge from this handbook, it would almost seem, so far as the army is concerned, that psychiatry, once called by the late Dr. Salmon the "Cinderella of Medicine", has lost its position of temporary recognition and has returned to obscurity and disfavor.

William C. Sandy.

Bureau of Mental Health, Department of Welfare,
Harrisburg, Pennsylvania.

College Textbook of Hygiene. By Dean Franklin Smiley and Adrian Gordon Gould. New York: The Macmillan Company, 1928. 333 p.

The college student has every right to have, and in some cases is beginning to demand, facts of hygiene that will make for health, both

physical and mental. When such information is made available in a brief, attractive, impressive, and understandable book, he becomes interested at once, whether he is of a scientific or an academic mind. Many students whose interest is purely cultural, to the exclusion of the scientific, will find this book of great value.

Its object, to quote the authors' own words, is "to present the facts of scientific health knowledge in simple form and as far as possible in non-technical language, so that the information may be put to immediate and continued use". This they have done admirably for the student and the teacher. The book is written clearly and briefly, though its brevity gives it rather the nature of a compendium, which may be disadvantageous for the casual or lay reader. There are numerous references at the end of each chapter, so that the source material can be investigated by those who wish more detailed information on a given topic, and a complete glossary of technical terms is a welcome addition to the volume.

In the introduction, tables of the "commonest physical anomalies" and the "commonest chronic complaints" are given, and the authors show conclusively that there is need for the supervision of a student in college from a medical standpoint. Their "health ideal", which is made up of eight items, lays great stress on the mental side of life. Two of the items will illustrate this:

> "1. To be able to carry out, during each eight-hour working day of the week, an ambitious program of activity with zest and without undue fatigue, nervousness, worry, or loss of weight."
>
> "6. To be able to enjoy as 'a legitimate means of escape into the world of unreality' or as an adequate means of self-expression for at least two hours a day, literature, art, music, drama, hobbies, or games, without eye strain, nervousness, or boredom."

The statement, "Mental traits which are apparently transmitted by heredity are certain factors in literary, poetical, and musical ability; insanity; feeblemindedness; and epilepsy", challenges curiosity and arrests attention, and therefore should be further developed and treated more fully.

The chapters on bacteria, disease, infection, resistance, and prevention, although brief, are conclusive and convincing.

The respiratory system is not dealt with as fully as it might have been. Stress is laid upon the common cold, tuberculosis, asthma, and hay fever, but pneumonia and the effects of poisonous gases on the respiratory system are not discussed. A few illustrations of the respiratory tract, especially of the thorax, would have helped.

The reader should find much valuable information in the discussion

of the digestive tract. The subject matter is well balanced, much attention being given to constipation and indigestion.

The nervous system comes in for its share of the book, and there is a great deal of information in this compact section. The section on sleep and relaxation is well worth the reader's time, as is the discussion on nervous-system stimulants. The point of view of the authors on mental disease is a commendable one, as they classify this condition as a major health problem and state: "If mental disease is even more common than stomach disorders, or heart disease, or tuberculosis, if it is no less understood and no more mysterious than these other diseases, and if, finally, the chance of prevention and cure is probably about as good as in the case of other diseases—then there is no reason why a person should hesitate any more to consult his family physician or a psychiatrist or mental hygienist about his nervousness, depression, insomnia, or unreasonable worrying, than he would hesitate to bring to the internist or specialist his digestive troubles, skin diseases, or eye defects for diagnosis and treatment or advice." Their discussion of the development of the emotional and intellectual life of an individual from childhood on, and the subsequent effect upon the future personality, is sound and full of common sense. The reader is not lost in a mass of psychiatric jargon and formulations, but can fully understand what the authors are driving at. The endocrine system comes in for a sound and interesting discussion.

In their discussion of the skeletal and muscular systems and their relationship to posture and health, the authors meet with a little difficulty. In treating of the prevention of curvature of the spine, they refer to Camp's "Daily Dozen". This exercise is not designed for posture work, as the authors would have it, but is a general hygienic measure. There is some danger in suggesting that the patient follow out his own program for correcting curvatures of the spine. The exercises should be practiced through supervised play supplemented by posture exercise, as outlined by Goldthwait and Klein. The authors advise such means as lifting the chin and contracting the abdomen, but these do not relate themselves to everyday living. What is required, in the beginning at least, is a postural diagnosis and treatment by a trained person. The authors have lost sight of this.

The chapter on choice of exercise opens with a statement of the exercise aims of Sweden, Germany, England, and America. The British and Americans, it is stated, use athletics as the mainstay of their exercise scheme, whereas Germans and Swedes have their own system of gymnastics. Since the late war, there has been a marked tendency for all peoples to use chiefly athletics and play as their ex-

ercise, and gymnastics in some form, either hygienic or corrective, to supplement where necessary. The authors have lost sight of this fact. Moreover, they might have given more information as to the treatment of postural defects.

The excretory, lymph, and blood-circulatory systems are treated briefly, but constructively.

The genital system does not suffer so much from brevity of treatment as the other systems. Its development, structure, physiology, and hygiene receive due emphasis, and the exposition should be of help to the college student. The hygiene of sexual intercourse and reproduction is discussed in a frank and open manner.

Exception could be taken here and there to the authors' views, and the arrangement of the chapters could improved. Some of the numerous illustrations, too, are not well chosen, for they presuppose more knowledge of the subject than the average student has, as, for instance, a drawing of a dissection of the paranasal sinuses on the left side. It is very doubtful whether such a drawing would convey much to the layman. But on the whole the work admirably fulfills its aim and will be found useful by those for whom it was written.

Clem C. Fry.

Yale University.

The Matrix of the Mind. By F. W. Jones and S. D. Porteus. Honolulu: University Press Association, University of Hawaii, 1928. 457 p.

This book is a bold attempt at the accomplishment of the task stated in its preface, which is to blend the sciences of neurology and psychology on the ground of their common physical basis.

The volume is divided into two parts. The first contains forty-three essentially neurological chapters with many intriguing and dramatic titles, such as *The Rise of Pallium, The Pallium and Awareness, What the Cortex Cannot Do,* and finally, *The Triumph of the Pallium,* suggesting to the layman the conquests of a Roman hero. The general flavor of the book is, therefore, essentially popular. In no way, however, does it lose its pedagogic value on this account; and as textbooks go, it could be substituted for any of the well-known dry textbooks of neuro-anatomy. It is dramatic and its plot does move with the authors' entertaining and often amusing observations, which make old things seem new. Even that foundation stone of all treatises on natural science, *Amœba proteus,* takes on a new garb and, through the authors' pretty subjectivity, gets a great deal of the "sense of aliveness", if not "awareness", injected into its pseudopodia in the

chapters devoted to these subjects. Where is the totally objective philosopher scientist who will not humanize the laboratory animal?

From the point of view of neuro-anatomy, the material is well developed and accurate. The author (I imagine Dr. Jones in this case) creates the term "cytoclesis" to denote an influence of cells upon other cells, of which Kapper's neurobiotaxis is a manifestation. In the treatise on structure and folding, a great deal of space is given to Dr. Baillarger and Dr. Gennari for their relation to the solution of cortical folding and lines of cortical structure, while Brodmann, Vogt, and Von Economo are dismissed with the statement that "vast strides have been made, and now we have come to recognize upwards of forty different fields of cortical structure".

The chapter on structure and function is excellent for the historical romance of Goll, Spurzheim, Hughlings Jackson, and Campbell. For the final conclusion that "the foldings of the pallium are an expression of pallial cytology", the clinicians of the war of 1914–1918 are given credit.

In dealing with the pallium and awareness, the cortical homunculus appears to be in direct relationship with the ego, and the subject is treated in the sense of Schilder's *Körperschema.* "In the human brain we have only to note the order of representation of the body, and to observe how it marches with the development of the visual pallial area, to be convinced that we have learned of ourselves from the muzzle to the hand and the eyes to the rest of the body. As the last attainment of knowledge of ourselves, there seems to be the area of the perineum, and, judging from clinical findings, it would seem that here the pallial knowledge was far from complete." This is of psychoanalytic interest.

The six-page chapter, *The Corpus Striatum and Its Private Path,* is very inadequate. Were the book a purely clinical treatise, this fact could be overlooked, but to have a phylogenetic attitude toward the brain with a wealth of comparative anatomical knowledge and not take advantage of the striate body is to have missed the great moment.

Part II, the psychological portion (I presume by Porteus), contains chapters 44–55, each possessing cryptic titles which take *Homo sapiens* again from *Amœba proteus* as a starting point for the consideration of human behavior, through certain biological pathways or behavior patterns, and through the chapter entitled *Senses and Sensitivity,* to the conclusion that "the cortex makes experimental procedure possible by making us less directly dependent on our sense perceptions". These pathways are concerned with what the authors call "cortical habituation", which is opposed to the fatigue theory

of the peripheral sense organs upon continued exposure to stimuli. Instead of peripheral fatigue, there occurs failure of the cortical impress. "Built-in habits", it is to be assumed, means generic behavior of the commoner scientific parlance. In *Neural Crossroads* the conclusion is reached that "the pyramidal decussation may be regarded as one of the fundamental requirements of four-limbed locomotion . . . and . . . a preparation for a more highly functioning cortex".

Monotony and Interest furthers the discussion of attention, memory, and the doctrine of cortical habituation, while the chapter entitled *Sense of Aliveness* ushers in the first use of the term "consciousness" and its synonymistic relation to attention. "Cortical memory and cortex cause continuity between flashes of awareness or the flow of consciousness", it is stated.

To the psychoanalytic school, the discussion of childhood memory and of "unreasoning fears and dislikes" would be amusing. We learn that "subcortical fears and cortical fears" differ entirely. The psychoanalysts are said to "err egregiously" regarding symbolisms in their relation to biological memories. The authors seem to be completely disorientated regarding Freud's unconscious or else they would not have confused structural with psychic levels.

The volume contains brilliant and stimulating bits of old material newly presented from the point of view of the two authors. But Chapter III, *Appearance and Behavior,* is full of absurd analogies, which give one an insight into the personality of the one of the two writers who is responsible for it. The *Leib-Seele* problem cannot be approached from the standpoint of academic psychology, it seems.

R. R. Dieterle.

State Psychopathic Hospital, Ann Arbor, Michigan.

Motherhood and Its Enemies. By Charlotte Haldane. New York: Doubleday, Doran, and Company, 1928. 253 p.

"What the home of the future might be can only be known when its problems have been investigated and solved by the one reliable method available to human beings: scientific method." This is exactly the attitude one would hope for in a book by the wife of J. B. S. Haldane.

Mrs. Haldane has collected a quantity of interesting information directly or indirectly relating to home and mother. This includes such material as data on syphilis among soldiers, Roman marriage laws, married-women-teachers cases, and the like. The book is much more limited than its title indicates, for the situation of the millions of women in Africa and China and other countries outside of Europe and the United States is not considered. This, however, makes it

more rather than less valuable. But unfortunately the use of such literary titles as *Foolish Virgins* in the table of contents and the absence of an index make it very difficult to discover the varied subjects which have been brought together apparently by the free-association method. Notwithstanding the irritation engendered by the fact that, while advocating "scientific method", it lacks a scientific index, the book is witty, informative, and readable. The concluding chapter especially is an excellent summary.

Mrs. Haldane conceives the relationship of the individual to the community as mostly a matter of live and let live; "his duties to himself are mainly positive, to others negative"—"to have enough to eat and drink and to have leisure; not to prevent others from enjoying what one knows to be indispensable or even unnecessary to oneself; to achieve self-respect before demanding or giving respect elsewhere".

The problems that center around motherhood she considers "the concern of all men as well as of all women". "Only a few will be able to deal with them creatively, but in order that experiment should not be wild and uncontrolled, it is necessary to have a public opinion formed by a benevolently critical minority. Such a minority must keep a sharp look-out for the results of scientific research, and must become acquainted with them; it must endeavor in speech and action to obtain full publicity and immediate application for such as may be of value. An intellectual guardianship of this kind will, in my opinion, be of far greater ultimate use to the race than active participation in half-baked eugenical schemes for which neither circumstances nor individuals are as yet prepared."

She discusses and dismisses birth control as a solution of the problems of the home: "It is children, not adults, who, as we have seen, 'make' a home. To reduce their number is to reduce the home life; to do without them is to destroy it. Birth control, though in certain respects it may, when sufficient knowledge renders it thoroughly practicable, overcome women's problems, cannot save the home. It may have precisely the opposite effect. . . . As a cure-all, it is an example of the dangers involved in hasty judgments, formed after the most cursory survey of the ills of adjustment to be remedied. Often its advocates seem to have formed no reasonable judgment at all, but to be merely relieving by this demand emotions outraged by personal or general suffering. The same applies to eugenics."

A real conflict between the sexes seems to her impossible, "for both sexes are united in their responsibilities towards their young. . . . The present conflict is chiefly due to the antibiological influence of the

Christian religion in the past, and that of female types who, while biologically superfluous, are nowadays socially and politically influential members of the community. . . . The vote, shared by mothers and spinsters alike, operates to some extent in favor of the unmarried as against the married woman."

She is opposed to the single standard, if that standard is to be the masculine one. " I believe and hope to prove that biology absolutely forbids such a standard for actual or potential mothers. . . . There may be a conflict between the sexual interests of the male and the female, when the latter is engaged with maternal occupations, and insistence on complete faithfulness of one man to one woman does not necessarily make for the absolute happiness of either."

Incidentally, there is an amusing misprint here, probably revealing the typesetter's own firm conviction. The author uses the Oneida Community as proof of her thesis that it is possible "for a white woman of a fairly high degree of civilization to know true love, and to find full emotional satisfaction, without necessarily being at all times the only object of one man's devotion". But in the text the "possible" appears as "impossible".

In considering the "factors at work antagonistic to monogamous marriage and home life", Mrs. Haldane stresses the problems created by the marrying of amateur prostitutes and the development of the "intersexual" woman.

She frankly admits that she has raised far more questions than can possibly be answered in the present state of our knowledge. "No satisfactory replies to the majority of them could be given except by scientific research workers and observers, and by them only after the collection of incontrovertible evidence, some of it biological, some statistical. All discussion of such matters must at present remain purely theoretical, and if I have succeeded in making out a case, it can only be one for investigation." This attitude is perhaps her most important contribution. Any book that asks for more facts about a central factor in civilization, instead of merely advocating action in hope, is worthy of praise.

EUNICE ARMSTRONG.

Scarborough-on-Hudson.

NOTES AND COMMENTS

Legislative Notes

AUSTRIA

A new juvenile-court law was enacted on July 18, to supersede a temporary law passed in 1919. Like the former law, it provides for the establishment in Vienna of a special juvenile court, and for the care of juvenile cases outside Vienna. Of special interest are the provisions (1) that the local branch of the state children's bureau, or, if none exists, another child-welfare agency, must be consulted by a juvenile court before it can make a decision; and (2) that all juvenile-court judges must have a knowledge of child-training methods and preferably some training in psychology, psychiatry, and education.

ENGLAND

The Board of Control, which is responsible for the administration of the lunacy laws, reaches some very definite conclusions concerning the marriage of mental defectives. It makes no definite recommendations for legislation, but clearly indicates the necessity for it, in the following statements:

"A careful study of the information before us leads to the conclusion that the marriage of defectives has disastrous consequences to the community, and that the time has come when definite legislative steps should be taken to prevent the marriage of those under normal.

"Children born to such parents are not likely to become healthy and useful citizens.

"Some of them, while still children, will need special and expensive provision in special schools, in industrial schools, in charge of probation officers, or in Borstal institutions.

"Many of them will develop criminal tendencies, and in one way or another, as they reach man's estate, they must become a permanent charge on the community.

SWITZERLAND

The following is a free translation of the sterilization law passed by the Grand Council of Canton Vaud, September 3, 1928, which was mentioned in the last number of Mental Hygiene:

"Article 1. The first article of the law of November 23, 1921, is annulled and replaced by the following: Article 1. (New) The present law applies to all persons suffering from mental disease, mental

defect, or from toxic psychoses (morphinism, cocainism, alcoholism, etc.) in so far as their state necessitates care or is dangerous to others or to themselves.

"Article 2. Section IV is inserted under the title 'Measures of Enforcement' and comprises the following, under Article 28½: Article 28½. (New) A person suffering from mental disease or mental defect may be subject to medical treatment for the purpose of preventing the birth of children, if he is considered incurable and if it is indicated that he can have only abnormal descendants.

"Medical intervention is to be taken only on the authorization of the Councillor of Health.

"The Councillor of Health shall not give this authorization until after sufficient investigation and upon the unanimous advice of two physicians chosen by him.

"He shall decide by whom the cost is to be borne."

UNITED STATES

California

The constitutionality of the Act of 1927, giving defendants in murder trials the right to make two pleadings in cases where insanity is presented as a defense, was upheld by a decision of the Third District Court of Appeals rendered September 28.

Connecticut

A plan for a traveling state mental-hygiene clinic, comprising a psychiatrist, a psychologist, and two trained psychiatric social workers, under the direction of the Mental Hygiene Bureau, is to be presented to the 1929 legislature by Mr. Edward F. Hall, Commissioner of Finance and Control. The plan entails an increase in the appropriation for the bureau from $10,000 to somewhere in the neighborhood of $50,000. It is the belief of Commissioner Hall that the number of applicants for admission to the state hospitals will be greatly reduced by this plan.

Georgia

Among the recommendations made by the September-October term grand jury, on November 2, was that of the creation of a separate school for mentally defective children.

Kansas

The constitutionality of the sterilization law was upheld by a decision of the Supreme Court of the State of Kansas, all justices

concurring, on October 6, 1928. A patent discrepancy contained in the law was also interpreted by the court.

Kentucky

The Hunter Sterilization Bill, which was recommended by the Department of Public Institutions, failed of passage in the 1928 legislature.

The Recodification Bill, which unifies and classifies the laws relating to the Feebleminded Institute and the insane hospitals, was passed by the same legislature.

Michigan

The sterilization question was brought before the public in September, 1928, by the refusal of the circuit court of Lapeer County to grant a habeas corpus releasing a girl from the State Home and Training School so that she might be married, unless she submit to sterilization. While supporting the superintendent's decision, the court takes exception to a part of the sterilization statute. The following quotations are from the opinion rendered:

"The statute authorizing sterilization does not permit the operation without the consent and approval of the party receiving the medical treatment proposed. It is not the purpose of this court to criticize the lawmaking body of this state, but it does seem strange that the judgment, will, and consent should be required of one who is without judgment and mentally incompetent.

"To permit this girl to marry in her present physical condition would mean in all probability she would provide the state with several more inmates of the various institutions as a result of her mating with this man, who admits himself to be an alcoholic addict."

Mississippi

The 1928 session of the legislature passed the following acts:

The name of the East Mississippi Hospital for the Insane, at Meridian, was changed to the East Mississippi State Hospital.

The sterilization act, summarized in the April, 1928, issue of MENTAL HYGIENE, became a law. In addition to legalizing sterilization it makes it a condition of parole.

A bond issue of $500,000 for new buildings, equipment, and improvements at the School and Colony for the Feebleminded at Ellisville was approved.

North Carolina

The 1929 general assembly will be asked to pass a law requiring the publication of notice of intention to marry before the license is

granted. The proposal is sponsored by the State Board of Charities and Public Welfare and is the direct outgrowth of the recent marriage of a feebleminded boy, who was suffering from a vicious form of venereal disease, to a feebleminded girl.

Pennsylvania

Interested persons who were disappointed at the defeat of the $50,000,000 bond issue will be pleased to learn of Governor Fisher's statement, on November 15, that $10,000,000 will be spent on welfare institutions during the coming biennium. The colony for epileptics now under construction at Selinsgrove and the proposed institution for male permanent mental defectives at New Cumberland will receive special attention in the drawing of the budget, the governor said.

A bill providing for the sterilization of the feebleminded is to be presented to the 1929 legislature.

The 1929 legislature is also to be asked to provide for two psychopathic hospitals, one in the eastern and one in the western end of the state.

Tennessee

The Knox County Quarterly Court voted, October 1, 1928, to erect a county insane hospital with such amount as is needed of the $100,000 authorized for a new poor asylum by the last legislature. The building will be at the poor farm at Maloneyville.

Texas

The 1929 session of the legislature will be asked to appropriate $150,000 for the establishment of a psychopathic hospital in Dallas. This hospital has already been authorized to be built either at Dallas or Galveston, and the proposed legislation has the backing of the Dallas Chamber of Commerce and the Dallas County Medical Society.

Washington

The State Federation of Women's Clubs has recommended the following bills to be introduced at the 1929 session of the legislature:

Establishing and outlining the policy of an institution for the feebleminded in western Washington.

Amending the marriage law that prohibits the marriage of a boy under twenty-one years of age or a girl under eighteen without the consent of parent or guardian; making the law more stringent; regulating the marriage of the unfit; and providing for an interval between application for and granting of marriage certificates.

Creating a children's code commission to study the welfare of children and their problems and report back to the legislature.

West Virginia

The formal opening of the new Federal Industrial Institution for Women took place at Alderson on November 24, 1928. The following description of the institution and its purpose should be of interest to all workers in the mental-hygiene field:

"This institution is located on the main line of the Chesapeake & Ohio Railway about halfway between Washington and Cincinnati and thirty miles west of White Sulphur Springs. It was created by Congress in an enabling act, June 7, 1924. March, 1925, the first appropriation was granted for construction, followed in July, 1926, by a second, which provided for completing the building. In June, 1928, the completed institution was turned over to the Department of Justice. The entire cost was somewhat less that $2,500,000. The town of Alderson donated 200 acres for the site and the Government purchased 300 more.

"The institution has been built on the lines of the best state reformatories for women, with the inmates housed in units of about 30. Each unit or 'cottage' has its own kitchen, dining room, and living room, thus affording ample opportunity for training in home making. There is a receiving and classification building for new arrivals and 14 other cottages for housing the remainder of the population, which will number 500 when the institution is used to its capacity. There is also a school and assembly combined, a hospital, an industrial building, a power laundry, a cannery, greenhouses, a poultry plant, a dairy, and facilities for all forms of farm and garden work.

"Previous to the erection of this instiution, the women who were convicted in the federal courts were lodged in county workhouses, jails, state prisons and reformatories, penitentiaries, or wherever the Department of Justice could find an institution to house and board them. The offenses for which they are sentenced are violation of the narcotic act (forbidding the illicit sale or possession of narcotics), tampering with or misuse of the mails, violation of the prohibition act, forgery, counterfeiting, and other offenses against the federal laws.

"The enabling act specified that the institution should offer training in the English branches and should fit the women committed to its care to earn their living when released. To carry out this purpose requires study of the individual cases in order that the time spent at the institution may be used most effectively both for the inmates and the institution. Individualization of treatment and training is the

fundamental principle on which the institution is proceeding. Every means and method found to be effective for rehabilitation in other institutions will be adopted in this. It is hoped to make and keep this, the first and only institution that the Government has built for women, an example of what can be done physically, industrially, mentally, and spiritually for the rehabilitation of this group. The Government has provided the necessary facilities which, if efficiently used and maintained, will make this an outstanding demonstration of intelligent treatment and handling of this difficult problem.

"The first inmates were received April 30, 1927. The population at present is about 200."

Wisconsin

The question of the sterilization of the feebleminded has taken a new form in the case of a Madison girl. Dr. Buerki, Superintendent of the Wisconsin General Hospital, requested legal advice from the state attorney-general as to whether a sixteen-year-old girl, about to be married, who has the mentality of a child of nine and a half years, might be sterilized. Both the prospective husband and the mother of the girl had given their consent. T. L. McIntosh, Assistant Attorney-General, who wrote the opinion, said: "Personally I think the facts you have stated would justify the legislature in authorizing such sterilization and that it ought to be done, but I do not find any law that would authorize such an operation on the minor mentioned."

Statistical Notes

England and Wales

The shortage of accommodations for patients in hospitals for mental disease and institutions for the feebleminded is indicated in the following review of the 1927 Report of the Board of Control which appeared in *The Lancet* for October 13, 1928:

Mental Hospitals

"On the first day of 1928 the number of notified insane persons under care in England and Wales was 138,293, an increase over the figure for 1926 of 1,667. The number of direct admissions was 21,893 —31 less than in the previous year. The ratio of admissions per 10,000 of the population aged 16 and over is now 7.66, and the table given in the report shows a steady decline in the last seven years. The general recovery rate is 31.43 per cent of direct admissions, and the general death rate is 7.94 per cent of the average daily number registered, against 7.30 per cent for 1926; that is the first rise in the death rate since 1922. The number of patients resident in county and borough mental hospitals increases on an average by 2,529 every

year. The number of vacancies, on the other hand, in spite of the reopening of Ewell Colony, Epsom, has deceased from 2,319 in 1926 to 1,570 at the beginning of this year. Moreover, whereas on January 1, 1927, there were vacancies for 148 women, there was in January of this year a deficiency of recognised bed space for 34. The position, in the words of the board, has become critical. As a temporary measure Ewell Colony, originally a hospital for male epileptics, was reopened last year as a mental hosptial with beds for 100 men and 329 women, and it is estimated that by the end of this year various small additions and rearrangements will have provided accommodation for another 1,250 patients—barely half the average annual increase."

Mental Deficiency

"Serious as is the shortage of accommodation for 'lunatics', the position of the constantly growing army of defectives who require institutional treatment is much more so, and the board report that, unless a great effort is made in the immediate future, it will become difficult and even impossible to administer the most important sections of the Mental Deficiency Act. Urgent cases needing prompt action frequently come to the notice of the board, and no vacancies can be found. On the first day of 1928 the number of defectives in institutions was 20,429; at the most moderate estimate—1 per 1,000 of the whole population—the number requiring treatment is 39,067. During the last six years the number of defectives of whom local authorities have obtained knowledge has increased from 25,470 to 61,522; many of these are reported to local authorities because they have got into trouble of some kind and need protection in institutions. The figures for the last few years of defectives recommended by education authorities show a progressive increase, which will become more rapid as education authorities awaken to the necessity of further care for defectives leaving school. Although most of these authorities have not completed their ascertainment and some have hardly begun it, the January returns show that 1,479 cases are 'awaiting removal to an institution'. Moreover, on January 1st there were 265 defectives in 'places of safety', that is, detained. This measure was clearly intended merely to ensure the safe custody of a defective during the fortnight or three weeks before a petition is presented, and detention for considerable periods without training or proper classification is obviously very unsatisfactory. Of equal importance, in the board's opinion, is the great and increasing difficulty in finding accommodation for cases reported from prisons, who otherwise have to remain where they are under admittedly undesirable conditions. The board do not mention, but certainly do not overlook, the deplorable handicap that rests

upon the infant, but highly beneficial enterprise of those benches of magistrates who employ trained psychologists to help them to keep defectives out of prison. Finally, the lack of accommodation in proper institutions results in the certification of a very large number of mental defectives under the Lunacy Acts, especially of low-grade and troublesome patients, for whom managers of small institutions and boards of guardians are naturally unwilling to shoulder the responsibility. Mental hospitals would be short enough of beds even if they were not obliged to shelter defectives, whom they cannot benefit and who hinder the recovery of other patients. The board consider the need to be so urgent that they devote much space in their report to an eloquent restatement of the numerous irrefutable arguments in favor of an immediate and adequate effort by all local authorities to found sufficient colonies to house all the defectives who in the interest of the community should be cared for in special institutions. The present shortage is, in their opinion, not entirely due to difficult financial conditions, but is sometimes the result of a failure by the local authority to realize the importance and gravity of the situation. Mental defectives are very prolific and always beget defectives; defective parents inevitably create centers of degeneracy, disease, inebriety, pauperism, and crime, for which local authorities cannot escape responsibility. The greater number of defectives who are given training early in life can be rendered harmless and amenable, cured of obnoxious habits, and under favorable conditions and proper supervision made self-supporting. The duty of all whose words carry weight with those responsible is obvious: to press and to continue pressing for the full and adequate recognition of the vital importance of this problem to the nation's health."

RUSSIA

The following data on the care of mental-disease patients in Russia is furnished by the Associated Press correspondent of the Washington *Star*, October 14, 1928:

"Russia has encountered a serious problem in caring for her insane citizens.

"There are only 77 lunatic asylums in the whole country, with accommodation for 21,103 persons. The public-health authorities say that there are five times that number of lunatics in Russia who ought to be locked up.

"Money for this purpose is hard to obtain in Russia and some of the existing asylums need repairs. There are no funds available for building new ones. The state finds it difficult to retain the 11,000 employes who care for inmates.

"Their dormitory facilities are crowded and working conditions

are far from attractive. Many have quit their jobs on the ground that they could not work longer without losing their own minds."

UNITED STATES

Patients in Mental Hospitals

The November, 1928, issue of the United States Public Health Reports gives the latest available statistics concerning patients in hospitals for mental diseases. Reports were received for the month of April, 1928, from 114 institutions located in 35 states, the District of Columbia, and the Territory of Hawaii. Twenty-two of these institutions are corporate or private. These hospitals reported a total of 167,199 patients, including paroles, on April 30, 1928. There were 89,040 male patients and 78,159 female patients, the ratio being 114 males per 100 females. During the month of April there were 2,875 first admissions to these hospitals, 1,687, or 58.7 per cent, being males, and 1,188, or 41.3 per cent, being females, giving a ratio of 142 males per 100 females. Of these first admissions, dementia-praecox cases constituted 17.9 per cent; manic-depressive psychoses, 14.6 per cent; psychoses with cerebral arteriosclerosis, 9.3 per cent; senile psychoses, 9 per cent; general paralysis, 8.2 per cent; and alcoholic psychoses, 5 per cent. Seven and five-tenths per cent were recorded as undiagnosed psychoses, and 7 per cent as without psychosis.

Hospital Beds and Patients

The extent of the provision for the care and treatment of patients suffering from nervous and mental disease is indicated by the figures given below, showing the number of beds and the average number of patients in various types of hospitals in the United States for the year 1927. These figures are from the hospital census of the American Medical Association, appearing in the *Journal of the American Medical Association,* March 24, 1928.

HOSPITALS, BEDS, AND AVERAGE PATIENTS IN 6,807 HOSPITALS, 1927

	Hospitals		*Beds*		*Average patients*	
Type of Hospital	Number	Per cent	Number	Per cent	Number	Per cent
General	4,322	64	345,364	40	228,084	34
Nervous and mental..	563	8	373,364	44	349,667	52
Tuberculosis	508	7	63,170	7	50,784	8
Maternity, children's and all other special.	1,414	21	71,420	9	43,297	6
Total	6,807	100	853,318	100	671,832	100

A comparison of these data shows that while the number of hospitals devoted to nervous and mental patients is only 8 per cent of the total number of hospitals, the number of beds exceeds the number of

beds in any other type of hospital by 4 per cent. Of still greater significance is the fact that the average number of patients in nervous and mental hospitals is greater than the average patient population of all other hospitals combined, being 52 per cent of the total. It is likewise of interest that while the number of beds in nervous and mental hospitals is only 4 per cent greater than that of the general hospitals, the average number of patients in the nervous and mental hospitals exceeds that of the general hospitals by 18 per cent.

Annual Meeting of The National Committee for Mental Hygiene

The National Committee for Mental Hygiene held its nineteenth annual meeting on November 8 at the Hotel Pennsylvania, New York City. Over three hundred members and guests attended the preceding luncheon, at which informal speeches were made by Dr. Frankwood E. Williams, Medical Director of the National Committee; Professor C.-E. A. Winslow, President of the Connecticut Society for Mental Hygiene; Dr. Arthur H. Ruggles, Superintendent of Butler Hospital, Providence, Rhode Island, and Chairman of the Executive Committee of the National Committee; and Clifford W. Beers, Secretary of the National Committee. Dr. Williams spoke on the First International Congress of Mental Hygiene, to be held in Washington in 1930; Professor Winslow summed up the results achieved by the mental-hygiene movement in the twenty years of its existence; Dr. Ruggles explained the need for a foundation for mental hygiene; and Mr. Beers outlined the plans and purposes of the American Foundation for Mental Hygiene recently established.

The outgoing officers of the committee were all reëlected for the coming year. They are: President, Dr. Charles P. Emerson; Honorary President, Dr. William H. Welch; Vice-Presidents, James R. Angell, Rt. Rev. William Lawrence, D.D., Dr. William L. Russell, and Dr. Bernard Sachs; Treasurer, Frederic W. Allen; Secretary, Clifford W. Beers.

The Social Science Research Council Offers a New Service

The Social Science Research Council has anounced the establishment of a new publication, *Social Science Abstracts*, the first issue of which will appear in March, 1929. *Social Science Abstracts* aims to provide the same service in the field of social science that *Chemical Abstracts* has for some years been supplying in the field of chemistry. All important new work in every sub-division of chemistry, no matter in what language the report of it is first published, is abstracted in *Chemical Abstracts*, so that its readers are always up to date in

regard to developments in their field. *Social Science Abstracts* will cover in the same way the seven great fields of cultural anthropology, economics, history, human geography, political science and government, sociology, and statistics. Arrangements are being made with European collaborators. The abstracts, however, will be in English. They will average about 150 words. It is expected that 15,000 important articles in periodicals will be abstracted the first year; the second year books, monographs, and serials will be covered.

The material will include periodicals literature in the field of social work that is of high enough quality to meet the requirements as to scholarship and scientific character. This social-work material will be found under the heading, "Social Adjustments and Social Agencies". The subheadings are: "Case-work with Individuals and Families"; "Community Work or Social Work with Groups"; "Community Planning and Administration"; and "Social Legislation."

Social Science Abstracts will be edited by F. Stuart Chapin. The editorial offices are at 611 Fayerweather Hall, Columbia University, New York City. The subscription rate is six dollars a year, including the annual index.

Comments from Scotland

In a memorandum of her observations on a visit to the United States last year, Dr. Kate Fraser, Deputy Commissioner of the General Board of Control of Scotland—one of an increasing number of European workers in the field of mental hygiene who come to America to study institutions and methods—makes various comments that will interest American workers who sometimes wonder what the impressions of these visitors from foreign shores may be.

Dr. Fraser, who was accompanied on her trip by Dr. Mary Knight of the mental hospital at Paisley, made a round of the principal hospitals, schools, clinics, and organizations of various kinds in the eastern part of the United States engaged in activities dealing with the mentally abnormal and the personal and social problems identified with them. They were impressed, among other things, by the importance we attach to the qualifications of psychiatrists and other personnel at work in our hospitals and clinics. Dr. Fraser remarks that the doctor must have "specialized in mental work and have had training in a mental hospital or institution for the mentally defective. In addition, he should have experience in children's diseases and in dealing with children. He should be a man of broad sympathies, with an understanding of children and of human nature, enthusiastic, and with a large fund of common sense; in a word, his personality is as important as his experience. In all the clinics I had the privi-

lege of visiting, the psychiatrist was a man of this type and eminently suited to the job. And I believe that the success of the movement in America is to a large extent due to the staffs appointed to do the work."

In a description of child-guidance work in this country, Dr. Fraser agrees with the American view that juvenile-court cases should be considered not as legal problems, but as social or school maladjustments, the correction of which should prevent such cases from ever coming into the courts at all. She remarks that this point of view requires emphasis, particularly in England. Dr. Fraser was also "impressed by the vigor, intensity, and thoroughness with which cases are handled in child-guidance clinics and by the practical and simple lines of treatment followed".

Describing the work for mentally retarded children in the public schools in American cities, Dr. Fraser has this to say:

"Special classes are held in ordinary schools. This is pretty universal throughout the states, with the exception of one or two special schools in Boston and Worcester. One of the principal reasons for preferring this seemed to be that it was felt that if a child was attending a special class in an ordinary school, he was not so noticeably different from his fellows, that there was less stigma attached, and therefore parents and children themselves objected less. It seems to me that the stigma would be more marked, at any rate among the child population. A defective would be much more noticeable by other children when attending a special class in an ordinary school than going to his own school, especially as he would have separate hours for play, meals, etc. Another reason was that of distance and the difficulty in conveying children to a special center. Still a third reason, and one on which great stress was laid, was that where industrial classes were held, the children attending special classes worked with the normal children in industrial work. This was considered to be a better training for life, partly because they would be working with their normal fellows in industry when they left school and partly because it was felt that a proportion of defectives equaled or even surpassed normal children in handwork. In my experience, although defectives are often wonderfully good at manual work, they only very exceptionally equal the normal boy. This would tend to lead to a sense of inferiority and would have a prejudicial effect on a defective, who needs encouragement so much more than discouragement."

Speaking of the need for follow-up work with mental-defective training in special classes, Dr. Fraser says:

"Generally speaking, the children are not regularly followed up

after leaving the schools, although in New York and other places small groups are being followed up. The visiting teacher in New York does follow up a few of those who live nearest her school, but the others are just left. A certain hold over then is maintained, however, by means of the instructions given to the parent when the child leaves school.

"Nothing is done to find employment for the children leaving school. In New York this was attempted, but was given up, as it was found that the child obtained employment better for himself. It must be remembered in this respect that industrial conditions in the States are very different from industrial conditions in this country."

With regard to the work done for institutionally trained defectives, Dr. Fraser feels that our methods have certain points of superiority over those of England:

"Both colony and parole methods appear to some extent to solve the problem as to the suitability of the institutionally trained defective to return to civil life. A patient who behaves in an exemplary manner in an institution, on return to civil life may fail utterly to make suitable adjustment, and it is only by a trial such as that given through colony and parole methods that his suitability can be estimated with any degree of accuracy.

"Our method of allowing a patient out on license does not meet the situation so adequately. When home on license, he is rarely working, he is on his good behavior, knowing that on this depends his ultimate discharge, and when his license expires, there is often difficulty in getting him back to the institution. It is not in any real sense a test as to the patient's capacity to live in the community, although it does test his capacity to live at home under strict supervision."

Commenting on the mental-hygiene movement in the United States, Dr. Fraser remarks that "mental hygiene occupies a prominent place in the community. The amount of time and attention given to this by all the physicians in charge of mental hospitals and institutions, as well as by those directly concerned in the work, is extremely significant. Dr. C. Floyd Haviland, Ward's Island, Dr. William A. White, Washington, Dr. C. Macfie Campbell, Boston, Dr. Adolf Meyer, Baltimore, to mention only a few of the famous psychiatrists, all devote much time and energy to propaganda in this field, and consider the education of the public in the laws of mental health and all subjects associated therewith to be an important part of their function. Prevention is the keynote of the whole movement."

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M. THÉRÈSE DE BERMINGHAM

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MENTAL HYGIENE

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MENTAL HYGIENE AND SOCIAL PROGRESS

STANLEY P. DAVIES, Ph.D.

Assistant Secretary, New York State Charities Aid Association

MENTAL hygiene has grown to be something much more than a medical specialty which merely gives treatment and help to individuals afflicted with mental and nervous disorders. If the task of mental hygiene were limited solely to the direct alleviation of human suffering, there would not be a great deal to be said about its social significance. The invention of modern anesthetics has, for example, contributed wonderfully to the relief of individual human suffering, and yet we do not often speak of the social significance of ether as an anesthetic. Modern surgery has been a truly marvelous boon to humankind in the relief of many of its ills and sufferings, and yet we do not ordinarily speak of the social influence of modern surgery. Other branches of medicine have a greater or less degree of social significance, depending upon the extent of the social problems created by the diseases that they endeavor to control. Work in the tuberculosis field, for example, has had a considerable degree of social significance because this disease has had so much to do with the creation of poverty and dependency and the train of social ills that go along with them.

Mental hygiene, however, is unique in the extent of its social significance. For one thing, the personality maladjustments with which mental hygiene is concerned have caused more social problems, and more serious social problems, than all other human ills put together. Not only sickness and poverty,

but crime, delinquency, family discord, industrial waste and inefficiency, and personal incompetence and unhappiness have been the direct results of mental maladjustments.

The social significance of mental hygiene goes even deeper, however, than the relation of mental disorders to the causation of social problems. Mental hygiene in its broader reaches is more than curative; it is more than preventive; it is a positive socializing force. Other branches of medicine deal with some one phase of the physical functioning of the body and stop there. Mental hygiene deals with the man himself, with the whole human being, or, as we say, with personality. Now personality, in contrast with heart, or lungs, or liver, is the very stuff out of which social relationships are made, and from which what we know as human society is built up. The whole progress of man—from the days of our crude, groping, dimly intelligent, apelike ancestors to our present high degree of social organization, knowledge, culture, and human well-being—has depended upon group coöperation—that is, upon the ability of one personality to get along with others so that they might work together, play together, rear and educate their children together, and generally protect and develop their common group life.

It is significant that in the struggle for existence, the large, fierce, solitary animals have tended to disappear from the face of the earth. The smaller animals who were individually weaker, but possessed stronger social natures, were able to band together for common defense and common development in a way that the fierce solitary creatures were by nature unable to do. Therefore, the smaller social animals survived in greater number in the struggle for existence. If man had been by nature a solitary animal, he would not hold the preëminent position in the world that he now possesses. Man's social qualities as an animal were the means of developing his human qualities, so that it may truthfully be said that we were social first and human afterwards. Human nature is social nature. Only because man has been a social animal has it been possible for civilization to advance. This is only another way of saying that the individual whose personality is such that he cannot live and work and play harmoniously with his fellow human beings definitely retards social progress.

If man is normally a social animal, then he who is not social is abnormal. And that is just what psychiatry has been showing us—namely, that a very large proportion of our social offenders and social dependents are mentally maladjusted persons.

Thus the reason for the preëminent social significance of mental hygiene among the medical arts is not far to seek. Any science and art that, working in conjunction with other social forces, can apply a technique, or exert an educational influence, that results in developing social personality has a social significance beyond all reckoning. This is frankly the aim of mental hygiene.

One indication of this social significance of mental hygiene is to be seen in the very nature of mental-hygiene treatment. The competent psychiatrist is aware that he can accomplish no constructive results with a maladjusted individual by studying the individual alone, without regard to his social relationships. What every good psychiatrist does, whether he uses psychoanalysis or some other method, is to study the individual in relation to his social environment. More often than not he finds in the social environment of the individual, either in the present or at some time during his life development, the factors to which his mental maladjustment can be traced. Furthermore, when the psychiatrist outlines a course of treatment for a patient, it is usually in social terms and consists of a program to be carried out with the aid of a psychiatric social worker. It involves the establishment or the reëstablishment of normal social relationships between the individual and his family, his neighbors, his fellow employees, and others with whom he must deal in meeting the requirements of life. That the psychiatrist does not concern himself alone with the individual or the mind of the individual as things apart, but only in their social setting, is simply another proof of the social nature of mind itself.

As Professor Cooley has stated: "All minds act together in a vital whole from which the individual is never really separated. . . . Social consciousness, or awareness of society, is inseparable from self-consciousness, because we can hardly think of ourselves excepting with reference to a social group of some sort, or of the group except with reference to our-

selves." In so far, then, as mental hygiene as an art is able to shape or reshape human personality, it is dealing with the most fundamental of social factors. It is shaping the very thing upon which social progress depends.

Socialization and individualization are not two different things; they are necessarily parts of the same process. We cannot socialize until we individualize. The whole can be no better than the units that compose it. Society can be no better than the individuals of which it is made up. How socialization and individualization have gone hand in hand may be traced in the development of our modern educational and welfare work. Educators, for example, have come to recognize that the best way to prepare children for social life is to deal with them less in groups and more as individuals. Constructive social work was unknown in the days when people were classified into groups and dealt with in groups. It was in the days when workhouses and almshouses of the vicious type flourished, when outdoor relief was given in indiscriminate and pauperizing fashion, when criminals were treated brutally and vindictively, that the socially needy were spoken of in such group categories as the worthy poor, the sick poor, able-bodied paupers, vagabonds, vagrants, panhandlers, hardened criminals, and the like.

The very existence of such careless classifications revealed the lack of any close analysis of these problems in terms of the individuals who composed them, and led to the development of a stereotyped procedure, applying to all within a given group, and thus really applying to none. Lombroso's classification of the criminal type, for example, in terms of certain physical characteristics tended to interfere with, rather than to aid, progress in dealing with the problems of penology. It was not until Healy and others began thinking and acting in terms of the individual delinquent that any real progress was made.

Similarly, as the mental-hygiene movement has progressed, the authorities in this field have found it advisable to throw overboard such terms as the insane and the feebleminded because they represent only lazy generalizations based on lack of real knowledge of the problems involved. Our most progressive psychiatrists are even tending away (except for

purposes of statistical reporting) from the use of standard classification of the various forms of psychoses in the actual diagnosis and treatment of patients, because they realize that a diagnosis of manic-depressive or dementia praecox in one case may represent an entirely different set of conditions and personality reactions from that in another case. So long as it is assumed that the mere determination of a diagnosis in itself indicates treatment procedure, just so long will psychiatry fail to deal helpfully with individual cases. To the competent psychiatrist, each case is different; no two are, strictly speaking, capable of being put into the same category, although there are doubtless resemblances. The constructive approach requires the study and treatment of each individual as a distinctly separate problem. Therefore, mental hygiene at its best is at once highly individualistic and peculiarly social in its methods and results.

To be concrete, we may consider specifically some of the ways in which mental hygiene is contributing to social progress. Mental hygiene's first and most obvious service in this respect has been the assistance that it has rendered in the understanding and adjustment of those who have so markedly failed to meet social requirements as to become social burdens or menaces. We think first in this connection of the mentally ill and the mentally defective, and of the success that has rewarded the psychiatric work which has been done in our state hospitals for mental diseases and our state schools for mental defectives in the treatment and training of these persons. As a result, a goodly proportion of the patients admitted to these institutions have been so improved that they have been restored to normal community relationships.

Criminals and delinquents are another large group of the socially inadequate whose understanding and treatment mental hygiene has greatly aided. There is no need to repeat here the statistics of various studies which show that a large majority of those who are apprehended as offenders against the law present mental and personality problems of the sort with which mental hygiene is best equipped to deal. Mental hygiene has added great weight to the modern constructive point of view in penology that society should concern itself

with the individual who commits the crime, rather than with the crime. Mental hygiene has given its strong support to those who regard personal and social rehabilitation rather than punishment as the objective that must be sought in dealing with the criminal. Mental hygiene believes that the question as to when, if ever, the offender can return to community life has no relation to any given number of years that may be fixed as the sentence for a particular form of crime, but hinges solely on whether or not, by means of psychiatric and other methods of treatment, the antisocial proclivities of the individual can be overcome, so that he may be a safe person to return to the community. This point of view is not one of coddling the criminal; it is hard-boiled enough in that it believes that, regardless of sentence, the individual who, despite the best efforts of treatment, remains antisocial should spend the rest of his days segregated from society.

Dr. William A. White has summed up the matter in saying that our prisons must really be made into laboratories for the study of human conduct and the possibilities of its modification along socially useful lines. Progress is already being made in this direction, as may be seen in the fact that the present commissioner of correction in New York State is a psychiatrist, and under him at Sing Sing Prison is a full-time mental clinic headed by a psychiatrist, for the purpose of introducing this approach into the prison system of the state. Mental hygiene is also making distinct contributions in the reform of general legal procedure relating to the trial, conviction, and sentencing of prisoners. The so-called Briggs Law in Massachusetts is a notable example of progress in this direction.

In those courts that have had organized psychiatric clinics, mental hygiene has proved its ability to render real service in giving the court a greater insight into the problems that come before it. That judges have found this service of great value is indicated in the fact that there is a great demand from judges all over the country for this kind of service. As a result of the work that has been done in the field of child guidance, beginning with the pioneer work of Dr. Healy, mental-clinic service has come to be regarded as almost indispensable in the children's courts. This is because mental hygiene has

offered to these courts for the first time an intelligent and workable plan for the early correction and prevention of childhood delinquency. Dr. Healy has fully described what these methods and results are. That they have been effective in accomplishing their purpose of making the first delinquency in many cases the last delinquency, instead of the beginning of a series of growing offenses leading to criminality, has been amply demonstrated. No longer are the children who come before our courts so largely the criminals of later years. Judge Hoyt, of the New York Children's Court, reports that in New York City, in spite of the increase in population, there has been no appreciable increase in juvenile delinquency. As a result of mental hygiene's contribution to the prevention of delinquency, we have every reason to look forward to a smaller proportion of serious crimes when the children of to-day become the men and women of to-morrow. That there is much work still to be done in this direction, however, is shown in the estimate that 93 per cent of the courts, dealing with a vast multitude of unfortunate children afflicted with conduct disorders, know practically nothing about them and summarily dispose of them by the infliction of punishment, usually in the form of imprisonment in some institution.

Another large group of the socially inadequate is to be found among those persons who become dependent and require charitable assistance. This type of social inadequacy may be wholly due to definite physical illness or physical handicaps or to a series of unavoidable economic circumstances. More often than not, however, the economic, personal, and social difficulties of the individual are but the reflections of personality shortcomings. Studies that have been made of the intake of the usual type of family-welfare agency from a psychiatric point of view have shown that a large proportion of such cases have a greater or less degree of mental maladjustment. It is, therefore, not surprising that social agencies have come to regard the use of mental clinics as almost indispensable to good case-work, and that some of the larger social agencies have seen fit to organize full-time mental clinics of their own.

The very evolution of social work, from its early stages of institutional care and undiscriminating and pauperizing relief,

through the stages of treatment, cure, and reform, to the modern stage of emphasis on prevention, education, and development of personality, has been in the direction of those things for which mental hygiene stands. Whereas our older forms of social work tended to develop the unsocial or antisocial type of personality, our modern social work is directed toward the development of the social type of personality. This shifting of emphasis has nowhere been better exemplified than in the family-welfare field. Nowadays, instead of breaking up a dependent family by committing its members to various institutions, and, so to speak, unsocializing them, every effort is made to preserve the family life by developing in the members of the family the capacity for self-support, and, as basic to that, the mental attitudes that will lead to family harmony and social adjustment.

Workers in family-welfare agencies that have been fortunate enough to have a mental clinic as part of their own organization have found that the mental clinic has offered them the means of solving many of their most difficult and baffling problems by giving them a new insight into the personality difficulties of the individuals concerned. After receiving the clinic's advice on such problem cases, the workers feel that they have somehow gotten at the heart of the problem, and are able to go ahead with a program in each case with a much greater degree of assurance. They obtain better knowledge of what may be expected of each individual, and how far he can, or should, be called upon to make his own decisions or to shoulder his own responsibilities. The psychiatric view gives definite assistance to case-workers by explaining why some wage earners are always changing jobs, or cannot hold positions, or can never obtain promotion to a more responsible job. In questions of financial relief, the mental insight into the case helps the worker to decide whether support is justified, and, for example, why some mothers can maintain a good living standard on a given allowance, while others on the same allowance can barely make ends meet.

The work that has been done with adults through a mental clinic operating in connection with three of the largest welfare agencies in New York City has proved to be more successful than was anticipated. When the adult is an isolated in-

dividual without family ties, his problem becomes increasingly serious and ultimately one that the community must face. The clinic has shown that much can be done through personality adjustment to lift such individuals from the level of dependence to a level of some degree of social acceptability. The following two cases dealt with are illustrative. I quote them from the report of Dr. Leslie E. Luehrs, chief of the mental clinic referred to.

There came to the clinic a widow of about forty years of age, unprepossessing in appearance, depressed over the recent death of her husband, and so preoccupied with her own ill health and her reminiscences of her husband's long illness and lingering death that she had become practically unemployable. The organization was confronted with the problem as to how far her physical and mental condition prevented her from working and consequently to what extent she deserved the support of a social agency. She welcomed the clinic as one more sympathetic ear into which to pour her troubles.

The clinic found that she had been employed as a waitress, more or less of a drifter about the country, that she had eventually formed a very real attachment for the man she had married and in her life with him had attained an emotional and economic security which she had lost with his recent death. Always having lived detached from her family and much to herself, she had developed a tendency to fantasying and surrounding her life with glamour. In such romantic fashion she was idealizing the memory of her husband. And while she did not show any definite psychosis at the time of the interview, she had developed a depressive state which might lead to a real psychosis as she grew older unless a very friendly interest were taken in her to make her feel she was not too much isolated and a definite attempt were made to improve her physical condition and to help her get work.

With the last point in mind, she was given a psychological test to determine her mental fitness, and while it was impossible to make a complete test, because of her apologetic attitude of "I can't do it—never could do it", there seemed to be no doubt that her intelligence was low. This, added to her depressed state, made the possibilities of her vocational adjustment even more dubious.

An exhaustive physical examination was given and some minor ailments were corrected. She was encouraged to return frequently to the clinic, and a worker was specially detailed to help her on a definite job-hunting program. She liked the clinic visits. The physical treatment and the interest shown by the worker gave the needed prop of friendly interest. She became rapidly more cheerful, although occasionally slipping back into her old self-commiserating attitude.

With continued encouragement and at the same time a kindly, but firm attitude on the part of the organization that she would, of course, soon be self-supporting, the woman, after several half-hearted trials, eventually secured a position as a combination housekeeper and mother's helper. She now is once more carrying her own burdens, is entirely self-supporting, and while probably still dwelling overmuch upon the loss of her husband, is, in view of her low intelligence and tendency to self-pity, making a very acceptable adjustment to the demands of life; whereas without sympathetic guidance and treatment, she might very conceivably now be in a hypochondriacal depression which would result in complete dependency or in the development of a psychosis necessitating hospital commitment.

The next case is almost the exact antithesis of the first in personality, for here we have a single woman of uncertain age, bizarre in appearance, but cultured in voice and manner; by profession, according to her own statement, an opera singer who, through illness and lack of engagements, has been reduced to destitution and is referred by the organization to the clinic because her grandiose ideas of contacts with great producers just awaiting her around the corner, and of prominent men standing in the way of her fame and fortune because of their jealous love for her, seemed on the face of it symptomatic of mental disorder.

A physical examination showed obvious malnutrition. Temporary financial relief took away the most acute worry. The clinic won her confidence by sympathetic attention to her story, which was quite obviously delusional and yet so difficult to evaluate that no diagnosis could be made. Undoubtedly, she possessed a good social background and good education and musical training. It seemed probable that she was

one of the many ambitious young women who, overestimating their ability, have trained for opera and been disappointed. Consequently, she had dragged out a miserable existence, teaching, coaching, until pupils had failed her and actual want faced her. To avoid facing failure, she had built up her delusions of grandeur.

All attempts to investigate her story were unsuccessful. Landladies knew her as "queer, but nice". Former pupils testified to her ability, but said that "her peculiar appearance was against her". The clinic advised convalescent care. Her board was paid for six weeks at the seashore, and she was then sent to the country, where she made an unusually good adjustment, being deeply appreciative of the courtesy shown her and the scenic beauty of the place. She returned to the city much improved in health, friendly, coöperative, but still persisting that a big contract awaited her. An attempt was made to ascertain her exact age, with the idea that she might qualify for an old-age allowance. She confidentially admitted to the psychiatrist an age well above the minimum for such allowances, and it was decided to place her tactfully on such an allowance. It was recognized that she would never secure an engagement and was too old and frail to attempt new lines of work or menial labor, but the plan was to keep her happy and encouraged by accepting her statements at face value and yet watching carefully for further development of delusional material that might necessitate commitment. Here we have an adult, potentially psychotic, peculiar in appearance and conduct, who can nevertheless be kept fairly happy and socially acceptable to the community by the intelligent, friendly, and tolerant supervision of a mental-hygiene clinic, alert to the possibilities of mental breakdown.

It might be well to stress that this is the type of case in which unsympathetic treatment or a harsh attempt to make the patient face reality would be dangerous; it is, therefore, essentially a case for psychiatric guidance.

Real social progress, however, consists of something more than merely bringing persons out of a state of social maladjustment back into harmonious social relationships. Society would not get very far if it consisted entirely of people who are simply keeping out of trouble. In other words, social

adjustment and nothing more is too static a conception. Society can progress only in so far as many of its members are dynamic and positive, and have the personality and ability to lead and to make definite contributions to human life. Mental hygiene has even more to offer in this positive sense of releasing and directing the best energies of human beings than it has in the negative sense of restraining those whose energies are liable to be put forth in antisocial directions.

Mental hygiene as a positive and constructive social force, in contrast with its merely corrective or preventive aspects, can, if properly applied, add something to the efficiency and happiness of every one of us. That does not, of course, mean that every person needs to go to a clinic and consult a psychiatrist. But it does mean that mental hygiene can offer itself as a useful ally to those constructive social forces in human life which touch closely the personal lives of all of us, such as home, school, church, and industry.

The home is the abiding place of the family. Sociologists have found no one factor in social life so fundamental, so universal, and so powerful a socializing force as the family. Despite alarms that have been spread concerning the increasing divorce rate, the extent to which social life has been transferred outside of the home, and other visible evidences that seem to indicate the break-up of homes and home life, the family is still with us, and we need not fear that it will not be with us for some time to come. Let any reformer start out with the intention of doing away with the family, and he would soon realize what a stable social organization it is.

From a sociological standpoint, the family is much more than a means of bringing men and women together for the physical upbringing of children. It is the medium through which the individual first becomes aware of himself as an individual, and, at the same time, as a member of a group. His self-consciousness and his family consciousness are for a long time, in the early development of the individual, practically indistinguishable. It is only in relation to the other members of the family group that the developing individual comes to know himself. It is not hard to understand, then, that what the child himself comes to be in personality reflects largely what the family is. Human nature and social nature, as we

have already stated, are but two aspects of the same thing, and it is in the family that these human and social qualities are first developed and find expression. If not in the family, where else can we hope to develop in the individual those qualities that are essential to the social type of personality—identification of self-interest with group interest, ability to work with others in a common cause, and a due regard for the rights of others?

When one considers what pliable material the young child is, and how completely the initial and, to a large extent, the permanent molding of his personality and character lie in the hands of the family, it is easy to see how the family may make or mar the child for social life. How can a child be expected to develop a personality motivated by ideas of fairness, give and take, honesty, reliability, altruism, and the like, if in the home he encounters nothing but discouragement, nagging, favoritism, jealousy, antagonism, and deception? How is the child to become a real man or woman if his mother insists on making a mollycoddle out of him, by encouraging infantilism, finickiness in food habits, an unwillingness to face difficulties, and so on? How can a child turn out a well-balanced, level-headed human being if his natural emotional cravings are able to find an outlet only in unsatisfying or unwholesome ways?

Even after the home gives up complete possession of the child and he comes under the influence of the school and other agencies, the home is, or should be, still his anchorage, the place where the deepest influences are at work. The need of parental understanding and of wise home management are all the greater when the child begins to get a taste of the world. During the adolescence of their boys and girls, parents need all the knowledge and wisdom to be obtained in helping the child to develop the necessary independence without throwing off all authority and restraint.

Mental hygiene needs, therefore, to be introduced into every home by means of widespread parental education. It may be that mental hygiene is already in the home without any awareness on the part of the parents, just because their intelligence, understanding, and common sense are of the sort that make for wholesome and constructive family life. We may hope

that this is true of the majority of homes. However, mental hygiene has developed some very simple and concrete suggestions for parents as to the guidance of their children with which even the most intelligent and successful parents should become familiar as a means of checking up on themselves. I refer to such educational material as has been made available by Dr. Thom and others. Dr. Thom's little pamphlet, *Habit Training for Children,* is a particularly good example. This pamphlet has been distributed by the hundreds of thousands, has been printed in a number of different languages, and is written so simply that any parent should be able to understand it, to profit by it, and to practice its suggestions. If parents throughout the world would put into effect the principles contained in this one pamphlet, the results in the lives of the next generation from the standpoint of mental hygiene and social progress would be incalculable.

There are, of course, many family situations that can be straightened out only with the aid of a child-guidance clinic. There is no doubt that mental hygiene has already accomplished very tangible results in making more families good socializing centers rather than bad, and that in the future, as this sort of educational and case-work extends into more and more homes, the social results will be very marked.

Next to the family, the school offers the greatest opportunity for the application of mental hygiene. Until within recent years, the school concerned itself scarcely at all with the health, the behavior, and the personalities of individual children so long as they were not disturbing elements in the schoolroom. The school took unto itself the task of teaching the children sent to it certain prescribed subjects according to a fixed and traditional curriculum. To the home it left the rest, not concerning itself as to how well or ill the home functioned. To-day, as the emphasis in our modern school systems is shifting from the teaching of subjects to the development of the child himself, the whole child, the school has frankly taken the position that it must attempt to make up for whatever shortcomings there may be on the part of the home. The modern school steps in, where necessary, and takes active measures for improving the nutrition of the child, for giving him dental prophylaxis, for providing various inocu-

lations against smallpox, diphtheria, and so forth, and for building up his health generally. The school even concerns itself with such fundamentals of home training as cleanliness and good manners.

Now mental hygiene proposes a working alliance with the school to the end either of supplementing or of counteracting, as the case may be, the influence of the home on the behavior, character, and personality of the child. It is a rare thing to find a school mental-hygiene problem that is not at the same time a home mental-hygiene problem. The experience of child-guidance clinics has shown that the adjustment of the problem child in school leads almost inevitably into the out-of-school life of the child in the home and neighborhood. This is why visiting teachers and psychiatric social workers are so indispensable in any school mental-hygiene program. Mental hygiene asks the school to take cognizance not only of those behavior problems that present disciplinary difficulties to the teacher and the principal, but also of any other forms of behavior or unusual attitudes on the part of the child that make him appear different or peculiar as compared with the healthy, well-adjusted child.

The school that aims to do real mental-hygiene work for its pupils must concern itself not only with the child who aggressively misbehaves, in forms of disobedience, teasing, bullying, temper tantrums, defiance of authority, bragging, showing off, pugnaciousness, and so forth, but also with the child who is too seclusive and withdrawn, sensitive or apathetic, moody or given to daydreaming. All such types of children are included in the term "problem children". Studies made by child-guidance clinics show that in the elementary schools some forty or fifty out of every thousand children are so poorly adjusted to school or home, or both, that they need careful mental-hygiene treatment to prevent them from developing definite personality handicaps.

Mental hygiene has had to win its way into the school system by actual demonstration of what it can do. The schools have naturally been on the defensive against specialties and movements of one kind and another that seek entrance into the school procedure. In those cities where the facilities of well-organized child-guidance clinics have been placed at the dis-

posal of the schools in recent years, these clinics have proven their value to the school authorities to such an extent that when the demonstration clinics came to an end, there was an insistent demand on the part of educators for their continuance from local funds. In practically all the cities where demonstration child-guidance clinics have been established, permanent clinics have resulted. It is encouraging to note that as a result of this five-year demonstration in child guidance, carried on by the Commonwealth Fund in coöperation with The National Committee for Mental Hygiene, the extent of child-guidance work has increased more than fourfold.

That child-guidance clinics have been able to achieve tangible results in helping school and home to adjust the personality problems of children is evident from a careful study of the case records of any of the child-guidance clinics. For example, a summary of the results of treatment of 136 full-study cases assisted by the Philadelphia Child Guidance Clinic showed 22 per cent to have been satisfactorily adjusted and an additional 34 per cent to have been partially adjusted, making 56 per cent of the group with whom real constructive work was done.

The work of mental hygiene in the public schools only begins with that small percentage of pupils who stand out as problem children. The personalities of the presumably normal children in these schools are still largely in the making. Although they may never appear as problems, these normal children have, indeed, very much to gain or to lose in their preparation for life through the impress that the school makes upon them. If the school is concerned only with the intellectual capacities of the children, and their ability to learn given subjects, if it insists upon a rigid adherence to certain fixed requirements for all children without making allowance for the great differences in their personal make-up and reactions, it may, while it is imparting knowledge, be doing definite harm to the child's real self. The child may be developing feelings of resentment, injustice, jealousy, inferiority, what not—attitudes that may become life handicaps—while the school machine grinds on obliviously. Interestingly enough, the emphasis that mental hygiene would place in general educational practice is blood brother to that toward which the most

progressive thinking in the educational field is leading. This common meeting ground of mental hygiene and progressive education is most obvious—namely, the development of the child himself as a social individual. That such an emphasis should be revolutionary in educational practice is amazing, but none the less true.

Practically speaking, mental hygiene can be most effectively applied in the school system by giving every teacher a working knowledge of the more simple fundamentals of constructive mental hygiene. Mental hygiene in the technical sense is not required. In the positive sense in which it should be presented to teachers, mental hygiene is not hard to grasp. It consists largely of an attitude and a point of view. Mental-hygiene instruction for teachers in training should be provided in the normal-school curriculum. For teachers already at work, there should be available lecture courses and institutes, with a certain amount of required reading.

The whole purpose is to give every teacher practical suggestions as to how, by her attitudes, her understanding of the varying individual needs of children, and her attention to the fundamental problems of personality, she can be an effective instrument in developing to the fullest degree in every child those traits of personality which will be his or her greatest assets in later life. Relatively few school children will ever need to be referred to a psychiatrist for study and treatment. In fact, there will probably never be enough psychiatrists to make this possible, even if it were desirable. On the other hand, there is not a child in the public schools who will not profit greatly when mental hygiene enters the classroom by way of the teacher.

Mental hygiene, then, is no new or foreign element in the school system. It points the way to the very highest type of educational procedure. Mental hygiene should become such an integral part of the school system, and be so completely identified with educational practice, that it will be impossible to distinguish between the two.

The church is another of those great forces in social life which, in the rush and hurry of the modern world, is called upon more than ever to give people the faith, courage, and strength with which to meet life's perplexities and complexi-

ties. Some people may be able to face their problems without a personal religion, but most people cannot. The church, like the school, is coming more and more to realize that it cannot give its greatest help to people in the mass; that the minister must be increasingly prepared to deal personally with the life problems of individuals. With this in mind, Dr. Harry Emerson Fosdick has recently suggested that something like the confessional be restored in Protestant churches.

It is to the minister, perhaps more than any other person in the community, that people are wont to come to unburden their personal troubles. To deal with these problems constructively, the minister has the need of something more than sympathy and exhortation. He must have insight, and often the insight with which he may be naturally endowed is not sufficient for the helpful understanding of the personal problems presented to him. Of what great value a general understanding of mental hygiene—the point of view again, rather than the technical training—may be to the minister, was recently indicated by Dr. Fosdick in an address before The National Committee for Mental Hygiene. He pointed out how psychiatrists have taught the minister that the person's diagnosis of himself cannot always be taken at face value, and that the real trouble frequently lies beneath the surface Through the psychiatrist, ministers have learned to trace back the psychological history of their cases, to deal with them genetically. Dr. Fosdick describes the following case:

"A woman came into my office some time ago saying she had lost her faith in God. I said, 'All right, go on and tell me about it.' She talked for about three minutes on how her theology had gone all to pieces. I said, 'Tell me that love story of yours.' She said, 'What?' I said, 'Tell me your love story. Of course, I may be wrong. It may be you have lost your mother, but I am betting it is a love story.' She said, 'What do you mean?' I said, 'What do you take me for? A fool? Do you think that you can talk as you have about lost faith in God without revealing that emotionally you are all messed up? Now, you have had a love affair.' She said, 'All right, I will tell you.' "

The intelligent minister, of course, recognizes that there are many persons who come to him whose personality prob-

lems have become so complex that it is beyond his ability to deal with them. He recognizes the need of calling in a psychiatrist for assistance in such cases. But the same thing holds here as in the school—probably in the majority of instances a psychiatrist is not required, and with a fundamental knowledge of mental hygiene, the minister himself will be able to achieve satisfactory results.

Dr. Fosdick, while expressing his unpayable debt to the psychiatrists for the aid that they have given in helping the minister to understand these personal problems, turns the matter around and says frankly that there are many cases that the psychiatrist cannot handle successfully without religion. Some psychiatrists would doubtless not agree with this, but surely a vital religion has been the one anchorage of people almost universally in the severe crises of life. Both mental hygiene and religion strike so deeply into the inner being of the individual that there is inevitably a close kinship between them, and on this kinship there should doubtless be based an intimate working relationship of the sort that Dr. Fosdick has suggested.

Mental hygiene has been responsible for the introduction of a new human and constructive point of view in personnel work in business and industry, at least in certain progressive, forward-looking establishments where it has been given an opportunity to show what it can do. It is scarcely necessary to point out that the increasing mechanization of industrial processes in these modern times puts an added strain on the industrial worker and thus has tended toward a growing number of maladjustments. From the purely commercial point of view, the maladjusted employee who, for one reason or another, fails to make good in his job is a person to be summarily discharged because he means a loss of efficiency and earnings to the firm. Many business organizations say, in defense of such a policy, that they are running a business and not a charitable institution. However, some business establishments have looked further than this. They have recognized, for one thing, that rapid turnover of employees is in itself a loss to the firm. Some employers have looked so far as to recognize that they have not merely an economic, but a human and moral relationship to their employees. It is

among this latter group of employers that mental hygiene has been given its opportunity.

An outstanding instance of modern mental-hygiene work in industry is that which has been carried on for some years past by R. H. Macy and Company, the largest department store in New York City, under the direction of Dr. V. V. Anderson. The aims of the mental-hygiene department are:

1. To supplement the work of the personnel, health, and other specialized departments;
2. To keep the employee on the job;
3. To prevent work failures;
4. To discover promotional material;
5. To deal with problem cases;
6. To find the underlying emotional and social factors of workers' maladjustments;
7. To work with the attitude of the employee toward his job, other workers, and his life situation;
8. To adjust the job to the worker and help make it an inspiration.

It has been found in this work that about 20 per cent of the employees of a mercantile establishment are problem individuals. This is the group among whom are found frequent transfers from job to job, general inefficiency, lay-offs, and resignations. From the mental-hygiene point of view, these persons are subjects for skilled study and treatment, that through a proper understanding of their personal and social problems, they may be satisfactorily adjusted to their daily work and become assets instead of liabilities to the firm.

Mental hygiene takes the point of view that such persons deserve another chance under the advice and direction of experts before industry has the moral right to turn them out as failures. For the adjustment of such problem individuals, R. H. Macy and Company has organized the same kind of mental-hygiene unit as has been found useful in dealing with the personality problems of people elsewhere—that is, a staff consisting of a full-time psychiatrist, a full-time psychologist, and one or more psychiatric social workers. This psychiatric unit studies the problem employees referred to it from four main points of view:

a. Social history
b. Job behavior
c. Physical examination
d. Mental examination.

As a result of these four inquiries, an insight into the individual as a whole is obtained, on the basis of which a constructive program for his industrial adjustment can be worked out.

In a recent article describing the work at R. H. Macy and Company, Dr. Anderson has cited a number of cases that are typical of the various kinds of problems referred to the psychiatric clinic and of the results obtained. The following case is illustrative of the type of individual whose problem is within his own personality. A young woman twenty years of age was referred by the buyer of her department on the ground that she was not aggressive and did not accomplish enough results in selling to earn her salary. The physical findings showed this young woman to be generally below par; psychological findings showed her intelligence to be average, with good learning ability; psychiatric studies showed her to have a personality make-up that was a distinct handicap to her in selling. She was found to be stiff and formal, aloof, stilted, self-conscious, shy, and retiring, with a tendency toward pessimism. On the other hand, she was extremely courteous and well-mannered and personally attractive, and she did not antagonize her customers. The social findings showed that she was single and lived in a girls' club. All of her close relatives lived in Europe. Her job behavior showed that she made only fair contacts with customers. While willing, she was lacking in alertness and aggressiveness.

The treatment consisted in first giving the young woman insight into her problem. Her coöperation was secured in carrying out a definite, prescribed régime for building up her health; also a program was instituted that would give her new interests in life and help to develop her personality in more outgoing ways through recreation and otherwise. As she built up her health, the program for her personal readjustment began to show its effect, and after a time there was a noticeable change in her outlook and in her attitude toward customers and her fellow employees. The department head reported: "Miss ———— has astonished every one by turning in the best books in her department since she came to your office. Her sales record has been excellent and the girl herself seems much brighter and happier." Ten months later the

follow-up record showed that she continued to lead her department in sales.

Another type of case is that in which the maladjustment is due not so much to any personality disorder of the employee as to a definite maladjustment between the individual's personality and aptitudes and the particular job in which he or she is engaged. The following case reported by Dr. Anderson is illustrative of this type.

A young woman of nineteen, employed in the store as a cashier, was referred by her superintendent because of the many errors she made in giving change. Physical findings showed her undernourished and underweight. The intelligence tests showed her to be below normal. She was slow in speed tests, poor in dexterity, fair in learning ability, and poor in accuracy tests. Psychiatric examination showed her to have an agreeable and attractive personality, enhanced by neatness and good clothes. Social findings showed the mother to be dead, the father married a second time, and the girl's home situation an unhappy one.

It was decided that this girl, by aptitude, would never be a successful cashier. On the other hand, her pleasant and agreeable personality indicated that she would suceed in sales work. Consequently, she was transferred to the house-furnishings department, where several months later the department head expressed himself as pleased with the new clerk. The psychiatrist has also advised her as to her home and social life, and has worked out a program whereby her leisure hours bring her a greater degree of happiness. Under the medical direction of the psychiatrist, her health has greatly improved. She has taken a special interest in the stock of her department, and is now being tried out for head of stock, a promotion for which there is considerable competition. She is showing trends of alertness, aggressiveness, and self-confidence that increase her effectiveness as a sales person.

There are, of course, other types of cases that cannot be adjusted under store conditions, and still others that have been tried and found wanting, both of which types had to be dropped from the pay roll. Of 500 employees referred from various departments of the store to Dr. Anderson as problem cases, 67 per cent are still in the store, and 23 per cent have

been laid off. Of the cases now active, 40 per cent have been adjusted and are no longer a problem to their departments, and 45 per cent are still under treatment. As Dr. Anderson states, "If every other problem employee can be adjusted on his job while he is continuing at his work, then there is not only an enormous saving in employment, training, and placement of new people, but (and this is of much greater significance) the individual problem worker becomes of some satisfaction to himself as well as to others, an asset not only to business, but to the community at large. At the same time, industry and business assume an obligation long neglected for the prevention of work failures which later result in social problems that become the burden of the general community." [1]

This approach to the problems of employees is something quite different from what is familiarly known as welfare work in industry. Group insurance, rest rooms, medical service, coöperative buying, housing schemes, and summer camps may all be well enough, but they are of advantage only to those employees who are able to stay on with the organization. They are not of much help to that 20 per cent of persons in industry who, without the skilled understanding, advice, and adjustment of mental hygiene, would find themselves forced to wander from one employment to another, with irregular income, while their social and personal problems kept accumulating. Mental hygiene offers to industry the definite opportunity of increasing the efficiency, morale, and happiness of its working force. Is that not a goal that any industry might properly seek?

From the foregoing instances, it becomes clear that mental hygiene is enabled to make significant contributions to social well-being only by merging itself quite completely with the great social forces in human life. Mental hygiene makes no claim to accomplish large social results by itself, working single-handed as a medical specialty. Mental hygiene performs its greatest constructive service by furnishing to home, school, church, industry, and other phases of social life a body of knowledge and a technique, to guide and aid them in the more effective accomplishment of their social mission.

1 "The Problem Employee: His Study and Treatment", by V. V. Anderson, M.D. *The Personnel Journal*, Vol. 7, pp. 203–25, October, 1928.

In this way the best mental-hygiene influences are often those that do not ostensibly bear the label—the good home, the wise school, humanized industry, and the like. In the broad sense, also, all those forces that add to the richness, satisfaction, security, and happiness of life are means of promoting mental hygiene. Thus literature, drama, music, and the cultural things; likewise, favorable economic conditions, improved public health, and so on.

When we come to examine social progress closely, we must agree that it consists of something more than mere economic prosperity or increasing health and longevity. Unless there are deeper influences directing the use of wealth, it may lead to human debauchery and social disintegration rather than to social progress. Similarly, improved public-health conditions are not the end of social progress. Public-health efforts that seek to give people more years of life and activity are thoroughly commendable, but they are not enough. What boots it for any of us to have fifteen years added to our span of life if these extra years are to be years of discontent and unhappiness, the crabbed old age of a never-well-adjusted personality? Hand in hand with public-health efforts to increase the quantity of life must go those constructive mental-hygiene influences whose aim is to improve the quality of life.

If we wish, we may, indeed, take the position of thinkers like Goethe, or the Polish philosopher, Gumplowicz, who denied social progress altogether. Gumplowicz, for example, insisted that what appears to be progress is only illusion, and that everything in this life tends to change and decay. We may take our stand with Herbert Spencer, who, while not denying social progress, felt that it was due to wholly impersonal forces, and that any conscious human endeavors toward social betterment only served to throw a monkey wrench into the machinery and impede the normal course of social evolution.

However, modern sociologists take a view with which most of us are more likely to agree—namely, that there is such a thing as social progress. Overlooking all the more superficial appearances of progress, these modern thinkers are pretty generally agreed that the final and fundamental test of social

progress consists in the increasing development in human life of the social type of personality—that is, of the type of individual who comes to realize that his own best interests and those of the group are one and the same, and who acts accordingly. If we accept this view of the sociologists, then the relation of mental hygiene to social progress is not far to seek. For the direct and specific purpose of mental hygiene is the development of the social type of personality, which is the very goal of social progress. Therefore, mental hygiene must be regarded as a uniquely useful instrument in the social order.

Mental hygiene courageously faces one of the largest tasks that mankind has ever undertaken. It denies that we must passively adapt ourselves to the god of things as they are. Mankind has already successfully challenged the physical forces of the world, and has marvelously adapted them to human needs. Now, mental hygiene, hand in hand with the home, the school, the church, and other social forces, insists that we need not accept even human personality as we find it. Mental hygiene has already begun to prove its bold affirmation that personality may be consciously improved and better adapted to social needs. With the further extension of mental hygiene, broadly conceived, there should be a steadily decreasing number of social inefficients and a steadily increasing number of social efficients—persons who, socially speaking, are able to put something worth while into life and, individually speaking, to get something worth while out of it.

This is social progress.

THE PSYCHOLOGY OF READJUSTMENT

WITH SPECIAL REFERENCE TO MENTAL-HYGIENE WORK IN COLLEGE

KARL F. MUENZINGER, PH.D.
Associate Professor of Psychology, University of Colorado

FLORENCE WEAVER MUENZINGER, M.D.
Medical Adviser to Women, University of Colorado

MENTAL-HYGIENE work in a college is concerned largely with supposedly normal and intelligent young people and therefore has its special limitations and aims, distinct from those of such work in the general community. A college is not organized to serve as a hospital or an asylum, or even as an institute for convalescents. There should be no problem of subnormal intelligence; and cases of mental illness, like those of physical illness, should always be referred to the proper agencies for such emergencies.

The function of mental-hygiene work in a college can then be regarded as parallel to that of physical hygiene: to help the *normal* individual to keep fit, to recognize and overcome injurious habits, and to develop resistance against possible disease. Mental hygiene in particular should aim to help students to solve intelligently their problems and acute "troubles" of an academic, social, or personal nature.

The psychology of the origin of such problems is fairly well understood and has received considerable attention. Psychiatry, psychiatric social case-work, and abnormal psychology have developed—largely in other types of communities, to be sure—a technique for the uncovering of the causal factors in behavior problems which can be used in mental-hygiene work in a college community. This article is not concerned with a discussion of such a technique or of the causal factors in maladjustments. It is concerned with the process of readjustment—that is, with the question of what happens after the causes of a maladjustment have been elucidated.

This process of readjustment is less studied, less well under-

stood, and perhaps less emphasized than the process of causation. Sometimes a belief is found among workers in this field that all that is necessary is to make the patient see the causes of his difficulties, to "give him insight", and then his case will "clear up". The notable instances of a psychology of readjustment, such as the theories of Freud, Prince, and Janet, which may be of great theoretical importance according to our particular bias, do not serve us here except as general guiding principles. They leave unsolved the concrete questions of what the psychological processes are that lead to readjustment, and how to guide the individual in order to start and develop these processes.

It is not to be denied that there are cases of maladjustment that do clear up after the individual has gained an insight into the causation of his troubles. Some of these readjustments are nothing but the lucky muddling through of everyday life, and the rest are due to a more or less intelligent conscious control by the individual himself. But there are also other cases that do not clear up after an analysis of the causation. They baffle the psychologist with the question: "I understand all this, but what am I to do to get rid of my worries?" It is for these cases that we need an exact knowledge of the psychology of readjustment in order to be able to guide them properly to complete recovery, to help them to a conscious control of their difficult situation, and perhaps even to give them a method by which they may overcome similar difficulties in the future. It is also possible that we may be able to benefit those cases that might have cleared up by themselves by replacing the "muddling through" by intelligent direction (on their part). A solution consciously achieved has a value not to be found in a chance solution, and only in this way can we be sure that a permanent recovery is taking place.

The material on which the following discussion is based is taken from the authors' experience in mental-hygiene work with college students. The usual practice of giving case histories has not been followed, because it is too lengthy and would mean giving too much irrelevant material. Instead, only excerpts from case studies are given, illustrating the psychological processes under discussion.

In essence the process of readjustment is that of substituting new habits for old ones. By habit we are referring not merely to explicit motor reactions, but to recurring emotions, attitudes, even lines of thought. Worry and fear must be replaced by confidence and courage, suspicion by trust, apathy by interest, self-consciousness by poise, seclusiveness by sociability, irritability by composure, and secretiveness by frankness. Recognizing these processes as habitual, we cannot expect any miraculous changes to take place overnight. Persistent effort only, sometimes over long periods of time, will bring about the desired results. This is a fact that must be fully recognized by the maladjusted individuals themselves.

There are no two cases that are alike. Individuals differ in their make-up and their experience so that in a certain sense each maladjustment is a unique problem. But just as it is possible to single out certain processes of causation that are common to many cases, so it is also possible to single out and describe certain common processes of readjustment. The following is an attempt at such an analysis.

1. *Clarification and change of purpose.*—All reactions, abnormal as well as normal, may be considered as integral parts of purposive striving. In every case of maladjustment, an effort must, therefore, be made to discover the relation of the abnormal reaction to an existing purpose of which the individual may be more or less aware. Thus clarification of purpose is the first step toward readjustment, as when a student is made aware that her hysterical attacks are really means of getting the attention of her friends. If the danger here is great that the psychologist may suggest a purpose not really present—a danger of which he must always be aware and which must make him sensitive to contradictory clues—the danger is even greater that in working toward a change of purpose he may suggest his own desires and needs as the guiding agencies, instead of discovering what would be natural to the student's native and experiential equipment. Among the numerous cases of social disappointment (snobbishness of classmates, no dates, and the like) are some students who successfully substitute scholarship for social life. Only the intellectually superior, however, can find entire satisfaction in this way, and even these will develop a one-sided

personality if they neglect the tendency toward comradeship and sociability. There are cases that show quite a resistance to a recognition of such social tendencies, which is shattered only after a careful discussion of past history and a demonstration of the possibility that such tendencies need different channels for outlets than those that have proved unsuccessful in the past. There is no case in which such clarification, and to some extent change of purpose, is not a fundamental process to be achieved. It can almost be put down as a law in mental hygiene that the clearer the purpose, the quicker and easier the readjustment. All the other processes described below can be thought of as integrating factors in this process of adjustment of purpose; they are always found to be dependent upon the existing purposes.

2. *Counterbalancing thoughts.*—In the case of persistently recurring thoughts—*e.g.,* thinking about discord in the family, or an injustice or insult inflicted by others—it has been found helpful to build up a counterbalancing system of thoughts to be recalled the instant the disturbing thoughts arise. A sophomore who was failing in his class work, after having established an excellent record in his freshman year, was found to be unable to concentrate on his studies because of ever-recurring thoughts about his family troubles. Among other things he was instructed to search for thoughts that he himself felt to be weighty enough to hold the scales against his troubles. He found these in his desire to help his family, which made it necessary to succeed in school. With the adviser's help, he formulated them in a definite way, so that he could repeat them to himself at the proper time.

To "control" such emotionally charged thoughts by an effort to exclude them from consciousness seems well-nigh impossible; they only come up with increased force. The only successful way of "control" seems to be to call up simultaneously thoughts which also find an integral part in one's purposive striving. This description is, of course, an arbitrary singling out of one aspect of a total reaction; emotions and overt motor reactions have to be attended to at the same time in each case. The best points of attack in this reaction complex are the thoughts and overt actions. We can institute these at will, especially if they fit in with existing pur-

poses. But not so with the emotions; they are not susceptible of such concrete handling except in a secondary way through thoughts and actions.

Sometimes the disturbing thoughts do not have the element of worry or any other strong emotional tone. They merely come at the wrong time like a tune running through the mind and detracting from an efficient handling of the moment. A student with an intelligence above the average did persistently poor work. It was found that he was a great reader and passionately fond of argumentation, although he rather talked than listened. In class he would pay attention to the lecturing instructor for about five minutes and then follow his own line of thought and forget the lecturer. Since he was anxious to make good for his father's sake, he was advised to go to class with the definite aim of making an outline of the lecture, so that at the end of the hour he could repeat the main points. Merely taking notes was not sufficient in his case, because he could take down what he heard and yet spin his own thoughts. He was cautioned to call to his mind the new aim whenever he entered a class and to repeat it to himself whenever he found his thoughts wandering. The success of his efforts was marked, although not perfect, at the end of a year.

3. *Substitution of overt responses* (*"habits"*).—Many maladjustments give way to new reactions when it is recognized that the latter serve certain fundamental purposes better than the former. If loud laughing and aggressive talking interfere with social success, it is possible to cultivate different modes of such reactions. The advice of this nature given to students includes such habit systems as conversation, eating, dressing, studying, and meeting strangers. It was found important that any changes in such habits should be recognized by the student as serving his purposes better than his old habits. But even then the maladjustment is not gotten rid of immediately for the reason that most of the habits are of old standing, and the new habits cannot be established merely by the desire to act in such and such a way. Even with a strong effort behind them, new modes of reaction have to be formed by a trial-and-error process with a more or less extended period of uncertainty leading to better and better control. A girl who was hiding a sense of inferiority and

social backwardness by rapid and loud talking was able to progress toward a more agreeable way of talking, but showed traces of her former ways even after two years, although removal of the cause of the feeling of inferiority seemed to have hastened the process. If the desired new reaction is anxiously avoided, it can sometimes be established through the bringing about of especially favorable conditions, as when one who is shy and avoids making friends is introduced to the right type of fellow student. Or sometimes it can be established through sheer repetition and a wearing down of the inhibiting impulses, as in the rather extreme case of a girl who, on account of an unpleasant experience with her former landlady, avoided the street in which this person lived. This avoiding reaction and the accompanying attitude were overcome by frequently walking past the landlady's house.

It might be objected that this is treating symptoms instead of causes. And so it is. It must be understood that the causes in these cases of maladjustment are supposed to have been uncovered by a preceding analysis (with which this paper is not concerned). Now it is a fact that in many cases even after insight into causes has been achieved, the symptoms still persist: thoughts wander from their task; ways of talking, dressing, working, resting, and meeting people remain the same; and worries and anxieties still oppress. These symptoms have become habit systems. They are now part and parcel of the behavior repertoire of the individual and their eradication must be effected by their gradual disuse and by substitution of different habit systems.

4. *Attaching emotional reactions to new persons and situations.*—There are emotional reactions, like vague fears and worries, exaltations and depressions, which do not seem to be connected with any definite situation, but pervade every waking moment and color all experiences. And there are others (called sentiments by Shand and McDougall) that are definitely attached to persons or situations. They may be called up as responses to the perception of those persons or situations, or they may arise independently of those "stimuli" and, with an uncontrollable persistence, remain in the foreground of our experience. It is this persistence that leads to maladjustments, because it makes it difficult or even impos-

sible for the individual thus afflicted to do his day's work efficiently. The perseverance of the emotional state is often caused by a resistance set up against it, for to say that it is caused by the strength of the emotional state is merely begging the question. Relief has been accomplished in such cases by attaching the emotional reaction to somewhat different situations, which would call out less or no resistance, whereby the perseverance of the reaction would be lessened and eventually lost.

In the case of "crushes", it was found that the advice to a girl to cultivate for a while the company and friendship of boys and of a larger circle of girls would bring a change in the obsessionlike brooding over the too intimate attachment to one of the same sex. This, of course, had to be accompanied by a frank explanation of the nature of crushes, their origin, meaning, and danger. It is doubtful, however, whether this information alone would have achieved the desired end. We can probably assume that the "normal" cases which do not come under observation "grow out of" their crushes by attachment to members of the opposite sex without any understanding of the nature of their homosexual tendencies and therefore without any ability to help others—their future children, for instance—to avoid the same danger. While there are many girls without homosexual tendencies and others who come out of this difficulty without understanding it, there are on the other hand quite a few who suffer from it. Many who are smitten with a crush experience the temporary insanity of lovers and do not even wish to transfer their emotions. It is for the sake of the latter classes that mental-hygiene instruction on this point is a necessary part of student guidance.

5. *Appeals.*—The reverse of the preceding process is the attachment of an existing emotional reaction to the present difficulty in order to change behavior. This is the process invoked by the usual method of "appealing" to some strong sentiment so as to make the reaction to the present situation an integral part of that sentiment. Some appeal may always be found that is successful in a certain case. We may appeal, for instance, to the ideals and the sense of values of the girl who is ashamed of her mother's occupation; to the sense of freedom and the life plans of the girl with a mother complex;

to the personal and family pride of the boy who is failing in his courses; to the self-interest of the student who habitually comes late to his classes and examinations; to the desire for adventure of the disillusioned.[1]

6. *Counteraction by fear of consequences.*—A special case of attaching emotional reactions to new situations is the invoking of fear of consequences. There are some in whom the desire to achieve professional success is strong enough to be influenced by a prospect of failure; there are others who can be reached by the wish to be well thought of by members of the family, friends, or the community at large. A girl with hysterical attacks of fainting (evidently a defense reaction during examinations, and the expression of a craving for attention) was successfully handled by a discussion of the kind of social attention she really wanted and by an arousal of fear as to what a history of such attacks would mean in regard to her plans for the future. Cases of this kind remind one of the hysterical cases during the last war that were cured by electric shocks or rather by their fear of such shocks. The psychological process of eliminating a reaction through fear is probably the same in both classes.

It might be said that the method of invoking fear is unethical and perhaps dangerous. We would answer that it depends on each particular case whether this characterization is correct or not. To invoke fear in a student who can be guided without it is certainly unethical and perhaps dangerous. As we approach the hysterical cases, however, we find that fear often is a simple and efficient impetus for changing behavior; if it is kept from developing into a permanent reaction, we do not think that its use is objectionable.

More so than with any other process described, we are often confronted with the fact that fear cannot be invoked or that if invoked, it is of no effect.

7. *The attitude of detachment.*—A necessary change in behavior leading away from maladjustment is sometimes difficult, if not impossible, to make on account of a sense of values that is incommensurate with the person's best purposes. Of

[1] See *The Psychiatric Social Worker's Technique in Meeting Resistance*, by Marion E. Rannells, MENTAL HYGIENE, Vol. 11, pp. 78–123, January, 1927.

frequent occurrence among students is an infantile relation to home and family which interferes with academic and social success. In such a case the reaction to the family occupies a central position in the student's behavior, so that all its little affairs fill his mind to the exclusion of his daily task. The adviser can often develop an attitude of detachment in the student's reaction to the home situation by an explanation of the necessity of breaking away from an infantile attachment to the home, followed by the suggestion that he formulate a scale of values as regards personal attachments in the light of his purposes. After all, the student must understand, he has to live his own life and accomplish his own aims; for this reason he cannot spend his efforts in brooding over the problems of others; he must ask continually, "What is more important than these affairs?" and he must attempt to look at them more impersonally.

A similar attitude of detachment on the basis of a new scale of values can be developed in cases of worrying over social difficulties. As a rule a campus has a well-defined stratification of social groups. Little tragedies and tragi-comedies are always occurring. Mostly they are lived through somehow, but sometimes they cause serious maladjustments so that it may seem impossible for a student to carry on in the same environment. Usually the past history of a student accounts for the exaggerated and always real suffering. An understanding of this causal relation is then the first step, to be followed by the revision of his scale of values ("What is important in the light of my purposes?") and a fostering of an attitude of detachment ("I cannot let myself be influenced by such episodes"). The student must also be informed that it is dangerous to go too far in detaching oneself from one's social environment, and that he must keep up contacts that seem valuable to him.

8. *Definiteness of attack and planning ahead.*—Naturally what is put down here relating to situations in general must be regarded by the reader as a series of formulas to be filled in by the concrete factors of an actual situation in order to be of any practical value to the student. The adviser must talk about what happened in the library, or on the campus, or at the dance. And he must insist on the same concreteness

when the student tries to meet his difficulties. If the latter goes away from his conferences with general aims and maxims, he is usually lost. It has been found of advantage, however, to let him go away from such a general discussion of the course to be followed with the instruction to come back with the concrete details worked out on a piece of paper. He is advised that, even after the present difficulties are overcome, similar ones cannot be avoided in the future and must, therefore, be met by the building up of defenses—that is, by having counteracting thoughts and attitudes ready. He must work out those thoughts in definite sentences and build up those attitudes by spending a definite time in asking himself certain questions and trying to adjust his attitude towards certain persons. (A girl who had difficulties in living with her housemates, whom she could not leave abruptly, was told to assume the proper attitude toward them by expressing it verbally to herself before she met them at the breakfast table and on her way from school before she reached the house.) With such a definite program in hand, failure and success in achieving a readjustment are reported to the adviser and analyzed with the purpose of changing and improving the plan.

9. *Self-help.*—In many cases the attitude of the student toward the adviser is not a desirable one and must be changed. Those with severe maladjustments are especially apt to expect the adviser to wield a sort of magic that will change their situation overnight, or furnish a sort of mental bromide that will put their troubles to sleep. Before any progress can be made, they must all realize that a readjustment can be achieved only by the student himself; that this means untiring and painstaking work on his part, sometimes over a long period of time; and that the function of the adviser is to clear up the situation and to make suggestions as to what course might be successful. The actual work must be done by the student himself.

10. *Change of environment.*—Any discussion of the psychological processes of readjustment must necessarily concern itself also with the relationship of a change of environment to a corresponding change in behavior. The obvious advice to any maladjusted person is to get out of his present environ-

ment and seek a new one. Many cases are benefited by such a (psychologically) simple method, because a new place and new people often do call out different reactions which lead to changed habits and attitudes. There are, however, other cases in which a change of environment has no such effect; purposes and attitudes remain unchanged and are transferred to the persons and objects of the new situation. Many students seem to carry their infantile and adolescent reactions from home and high school into boarding house and college. The physical situation has changed for them, but psychologically its function remains that of the old situation. Students who suffer from delusions of reference, who believe that their acquaintances talk about or even plot against them, are not necessarily benefited by a transfer to another university, because they also transfer their morbid interpretation of the behavior of their social environment. In a very literal sense, the character of their psychological environment remains the same, although their physical environment is changed.

We can classify this complex relationship as follows:

1. There are cases in which a change of environment is of no effect. (Delusions of reference are carried from one situation to another; so may be any other habits or attitudes.)

2. There are cases in which a change of environment is not essential, although it might make the process of readjustment easier. (A girl suffering from social neglect would do better in a small college or a girls' college, but it is possible for her to overcome her difficulties even in a large college with a definite social caste system.)

3. There are cases in which a change of environment seems imperative, because a persistence of the old situation would be a constant danger during or even after readjustment. (A girl suffering from a crush, a boy dominated by his mother, are exposed to influences that inhibit a readjustment. Yet even here, except in cases with strikingly abnormal trends, it seems an open question whether with deepened insight and improved methods of therapy we should still have to insist on a change of environment.)

This discussion must not be understood as an argument against the function of the environment in shaping character.

Nor must it be taken to mean that bad conditions and situations need not be changed. Although our aim in mental-hygiene work is to help students to live in the conditions in which they find themselves, we must not forget that it is also our duty to work for a change of those conditions which are continuous causes of maladjustments on a campus.

We may say, then, that in all these cases *a change of the psychological setting* is the primary aim of mental-hygiene work and that it can be accomplished in a majority of cases without a change of the physical situation. In actual practice we may even go further—that is, we may attempt in every case to bring about a readjustment without a change of environment, resorting to such a change only as a last method.

The advantages of such a procedure are of two kinds, practical and psychological.

1. It is very often difficult, if not impossible, to effect a change of environment. A student who lives with his parents in the college town cannot easily leave home; or he may not have the means to go to a different college.

2. If a change of environment is not planned, the student realizes from the beginning that there is no possibility of "running away" from his difficulties. He must face these frankly and solve his conflicts rationally without any muddling through. This means an insurance against future maladjustments. If a similar situation arises later on, he will have certain methods ready to meet it and his confidence, due to the first successful readjustment, will be of no little value. There are cases in which such a treatment seems harsh, at least to the student. Thus the adviser is forced to do much patient explaining that each person supplies to his world his own meanings and interpretations according to his purposes and desires; that each person lives in his own psychological world which is different from that of his neighbor's, although both live in the same physical and social world.

This change of the psychological situation at times means the substitution of conscious desires and purposes for unconscious ones. The girl who is made to realize that she craves attention and is actually getting it by hysterical attacks may be able to overcome her difficulties by planning more definitely

for her professional career and through fear of failure because of the attacks. An infantile unconscious desire is thus supplanted by a conscious adult purpose. It goes without saying that desires are not thought more important because they are unconscious—that is, not fully recognized and understood. If unconscious, they must be brought to awareness and subjected to a test by more ultimate desires and purposes.

In guiding a change of the psychological situation of the maladjusted, the adviser cannot hide entirely his own personal bias and prejudice. As pointed out above, he must always be aware of the necessity of preserving the integrity of the maladjusted person and not inject his own desires into the student's world if they are foreign to it. This again requires, as in all other difficulties, that the student himself must see the danger and guard against it. It may even be necessary that the adviser warn the student not to accept the adviser's evaluation of the factors of the situation, but to work out his own. Such dilemmas have been found especially in difficulties of a sexual or religious nature.

In conclusion, it may be pointed out that in some cases it seemed as if the process of readjustment not only helped the student to a clearer understanding of himself, but also gave him deeper insight into the fundamental problems of life itself. In many cases the adviser can hold out the possibility that a frank facing of the difficulties, with an understanding of their causes and a conscious control of their solution, will give the student a certain wisdom of life which otherwise, if his path had been quite smooth, he would have missed; that if he tries to work out clearly each step of this episode, he will gain a deeper understanding of his own nature and that of his neighbors. We feel confident that there were at least some cases that achieved this insight and understanding and thus added to their wisdom of life.

PSYCHIATRIC SOCIAL WORK IN THE FIELD OF EDUCATION *

ELMA OLSON, M.S.S. (Smith)
Psychiatric Assistant, Department of Mental Hygiene, Yale University

"EDUCATION moves from above downward", said Patty Hill in speaking of the nursery school and the present social order. She makes the point that hitherto the youngest members of society have been ignored educationally until the needs of the colleges, the high schools, and the elementary schools were well established. And if we review the history of psychiatric social work in the field of education—that is, if one can speak historically of anything less than ten years old—we find pretty much the same order of development. The psychiatric social worker, as she became a part of the educational system, also progressed from above downward, with one exception. The order is: high school, elementary school, university, and nursery school.

No record has been made of the first professional meeting of student and psychiatric social worker. We know that problem cases were seen by psychiatrists before psychiatric social workers were employed. This was the case in 1921 when a New York City high school began referring several of its problem cases to a psychiatrist who acted in an advisory capacity. Agencies organized for purposes of child study—such as the Illinois Institute for Juvenile Research, the White-Williams Foundation, the Judge Baker Foundation, the New York Bureau of Child Guidance, and the child-guidance clinics established throughout the country since 1922—received pupils from the schools. Through these complete clinical units psychiatric social work probably made its earliest contacts with educational institutions.

* Read as part of a symposium on "Psychiatric Social Work in the Field of Education" at the annual meeting of the American Association of Psychiatric Social Workers, Memphis, Tennessee, May 2–7, 1928. For the other papers in the symposium, see pages 271–77, 278–88, 289–97, 298–308, of the present number of MENTAL HYGIENE.

In these earlier cases problem students went from the school to outside agencies for psychiatric study. And in the field of education, as in the field of medicine, psychiatry was first employed in the cause of the seriously maladjusted. As psychiatry first ministered to the psychotic in mental hospitals, so did it first lend its technique to the severer forms of maladjustment in the school. The students first referred were such definite failures, personally and academically, that they could not escape the most casual notice.

But new emphases were quickly forthcoming. Important among them was the tendency to organize within the school system a student personnel department or program with a mental-hygiene approach. This adventurous step in progressive education was first effected in 1923, when the high school at La Salle, Illinois, created its Bureau of Educational Counsel, with a psychiatric social worker in charge—the first instance in the history of education in which a psychiatric social worker was employed by a school and given faculty rank. Although the funds were supplied by a private donor, the school board and principal exercised the same supervisory power as over any other department of the school system. The main objective of this bureau was the careful study of the individual student, with general emphasis on the study of behavior, the development of personality, and the adjustment—or, better, the foreseeing and preventing—of emotional conflicts common to adolescent life. The plan was intensive; it stressed from the beginning individual attention to every student in the high school. And it was unique in that it placed the major emphasis on the superior student. The extension of this program to the junior college two years later probably represents the only instance of a psychiatric social worker in a junior college.[1]

The next high-school experiment, different in organization and development, appeared in 1925 in the Lake View High School, Chicago.[2] The only other project within the high school on which we have any data is that in Newark, where

[1] See *Psychiatric Social Work in the La Salle-Peru-Oglesby Junior College,* by Lila McNutt, pp. 271–77 of this number of MENTAL HYGIENE.

[2] This interesting plan is described by Mrs. Platner in her paper, *A High-School Demonstration Clinic,* pp. 278–88 of this number of MENTAL HYGIENE.

the psychiatric social worker works in coördination with the visiting teacher.

The elementary schools follow the high school in order of development of psychiatric social work. They have the greatest number of projects, as well as the greatest number of workers employed. Undoubtedly the most outstanding program is that of the Department of Child Guidance of the Newark Board of Education, which represents an elementary-school population of over 62,000. Aside from psychiatrist and psychologist, there are five psychiatric social workers on the staff, with three more to be added.

Occasionally a system of public schools supports a personnel department in which psychiatric social work is one of the divisions. This is the situation in Los Angeles, where the city schools have a department of psychology and educational research. In this department is a psychological clinic with a staff of four psychologists. They are assisted by three social workers from the social-service division. This division was established in 1925 and serves not only the psychological clinic, but assistant superintendents, supervisors, principals, parents, social agencies, and the schools directly.

The most common set-up in the elementary schools is a single psychiatric social worker with the part-time assistance of a psychiatrist and a psychologist. Usually the school board finances the program; in one case a woman's club is giving the services of a psychiatric social worker for two years, hoping that the board of education will then take over the project. Occasionally we find that a psychiatric social worker is also a visiting teacher who may or may not have been first placed by the National Committee on Visiting Teachers, as a demonstration, and later taken over by the school board.

Two private schools have psychiatric social workers on the faculty. One is a special type of school—the Glenwood Manual Training School, at Glenwood, Illinois—a year-around school for dependent boys from grades three to six. Here vocational guidance holds a very important place, and the worker is called a vocational counselor. Her clinical affiliation is with the Illinois Institute for Juvenile Research. In the Lincoln School in New York City the psychiatric social worker has the assistance of a consulting psychiatrist.

Because of the number and variety of projects in elementary schools, it is impossible to speak specifically of them. The program in a small community, in which the problems of organization and education are undoubtedly typical of many, is discussed in a separate paper.[1]

Although several colleges and universities have been employing psychiatrists as consultants on student problems for some time, it is only very recently that a psychiatric social worker has been given a place in a college program. In October, 1926, Yale University secured the services of a part-time worker in its newly created mental-hygiene program for students. In September of the same year, the work was extended on a full-time basis, and a worker was employed as psychiatric assistant to the five psychiatrists doing student personnel work in the mental-hygiene department, which is a part of the medical school and is in close working association with the university health service. Student problems are handled directly by the psychiatrist and in some cases solely by him; although there is direct contact with students by the social worker, her efforts are directed more largely to investigation and social therapeutics as applied to the student's home and university relationships.

At the University of Michigan the psychiatric social worker has a slightly different rôle. She was employed last October by the university health service and makes the first contact with the student. Psychiatric problems are referred to the psychiatrists on the staff of the university hospital, after the social worker has taken the preliminary steps usual in any psychiatric clinic in the way of investigation and social history.

As the nursery school has been the last of the educational institutions to be established, so has it also been the last to employ a psychiatric social worker on its staff. Such organizations have been effected in the past year in two cases—the Cannon Nursery School in New Haven and the Tom-Tit Nursery School in Brooklyn. In both cases a psychiatric social worker is one of the two directors of the school. Before

[1] See *A Mental-Hygiene Program in Grade Schools*, by Elizabeth Allen, pp. 289–97 of this number of MENTAL HYGIENE.

that service was secured from child-guidance clinics and other service agencies.[1]

The foregoing résumé is probably a fair representation of psychiatric social work as it functions in educational institutions from a service point of view. In all of these organizations the major emphasis is on case-work as the technique—on service as the aim. Although psychiatric social work may be considered usually in terms of service, it has another important function in its educative rôle. As an art, its technique is taught in professional schools of social work; courses of instruction are given to allied groups—to nurses, medical students, teachers, and parents; lectures popularize the subject, demonstrations teach its practical application, and papers and research make their contributions to the educative process. Indeed, the educative process is not confined to this country, for, with the assistance of one of our psychiatric social workers, it is being extended abroad.

When one reviews the achievements of the five years of psychiatric social work just past, one cannot but be impressed with the developments. However, we should not be so concerned with measuring the signs of progress that we fail to recognize some of those factors that tend to impede progress. What are some of these obstacles, particularly as they exist in the educational field?

1. Educators will, of course, quote the item of expense. This may be a very real one in some cases, but usually that is forthcoming which one finds one cannot afford to do without. Psychiatric social workers may be not able to affect noticeably a certain pecuniary situation except as they can prove the economic worth of their job.

2. We also hear the point made that trained workers are not available to meet the present demand. This obstacle is being removed by the increasing numbers of trained workers graduating from their courses each year. One school is graduating about three times as many psychiatric social workers this year as it did five years ago.

3. There is a common confusion of mental hygiene with

[1] Mrs. Rademacher, who is the pioneer in this field, tells of her experiences in her paper, *The Psychiatric Social Worker and the Nursery School*, pp. 298–308 of this number of MENTAL HYGIENE.

Freudian theories as they are currently misinterpreted, and this confusion affords opportunity for the school gossip more or less common to every community. Some students and parents will misinterpret and distort, and these misinterpretations and distortions are not easily corrected. In the smaller, conservative communities, the psychiatric social worker has quite a real responsibility in the formation of community attitudes toward her work, for she stands as representative of it. Occasionally a social worker fails to apply her technique to this end; she may be insensitive or indifferent to community attitudes, or she may improperly evaluate them. For instance, when a worker who was neither a novice nor a flapper was asked over the luncheon table by the conservative wife of an important business man if she believed in "free love", she replied that she certainly did. Her answer was not without humor among her friends, who knew her to be as conventional as the conservative questioner, but it was regarded quite differently over the bridge tables of the equally conservative community which supported a mental-hygiene program in its schools.

4. Perhaps the greatest obstacle is that the average educator is not yet acquainted with the philosophy of mental hygiene. Mr. Slesinger makes this point in his recent article *Professor versus Psychiatrist*,[1] where he makes the further point that the psychiatrist is no more familiar with the professor's philosophy. He adds that "by interest, training, and temperament, these two professions look at life differently". And observing the reactions in both fields, one finds these differences apparent. To the psychiatrist the personality of the student is all-important, and he is interested in the educative process as it affects therapeutics and personal adjustment. The educator, on the other hand, tends to measure his student in terms of academic adjustment—that is, in terms of academic status. A psychiatrist reports to the dean that a certain student has been suffering from nervousness and insomnia and concludes, "But he's getting along all right." The dean, emphatically serious, responds, "But he's *not* getting along all right." Both are speaking correctly, but

[1] The *Survey*, Vol. 59, pp. 761–2, March 15, 1928.

from an individual perspective. The dean is thinking in terms of low grades; the psychiatrist from the standpoint of therapeutics.

Whether the academic setting be elementary school, high school, or university, the situation is essentially the same. The emphasis of the psychiatrist would remain unchanged, for whether his patient be child, adolescent, or adult, his major concern is therapeutics. And with the educator, his emphasis varies only in so far as his immediate problems are those of teacher, professor, or dean. Of course, there are outstanding exceptions in both professions, or we would not find the marked progress of the last five years coördinate in the two fields. I am thinking of one educator about whom a psychiatrist remarked, "He is no less a psychiatrist than an educator"; and a psychiatrist—who, by the way, is not connected with an educational institution—recently commented, "It seems to me, more and more, that it is necessary for a psychiatrist to have more of the educator's point of view." There are those who see beyond the immediateness of the particular job, but in the main there is need of a better coördination of points of view—if not of a synthesis of points of view—in the two fields—and this will not be accomplished by wholesale and damning criticism of each profession by the other, which seems to be the method occasionally employed.

Perhaps this business of coördination is largely the task of the psychiatric social worker. One of the emphases in her training for case-work is that she must be an interpreter, not only between personalities, but between this organization and that institution. Might she not also be an interpreter between professions? To what extent can she take the responsibility of interpreting mental hygiene to educators and the educational point of view to psychiatrists? Perhaps this is done sporadically and indirectly wherever there is psychiatric social case-work in an educational institution, but might it not be done more consistently and more directly with as much emphasis as is being placed on the case-work itself? Certainly the psychiatric social worker holds a strategic position. If she assists in this task of coördination, her responsibility is not only that of interpreting mental hygiene to the educator,

but is equally that of interpreting the educator's philosophy to the psychiatrist.

And what of results—so far as results can be even suggested for so short a period of experimentation! We find the optimistic educator and the pessimistic psychiatrist as well as the optimistic psychiatrist and the pessimistic educator. The psychiatric social worker, on the whole, seems enthusiastic. But it all depends upon the individual point of view. Take that of the janitor, for instance, who passed judgment on four years of psychiatric social work in his particular high school. This janitor was reputed to be a crank, a recluse, and a misogynist, and his pet aversions were mischievous youngsters and women of the faculty. After four years of careful propinquity in the same building, I was approached on my leave-taking by him with the question, "Well, Miss Olson, do you think you accomplished anything?" I was impressed, not because he condescended to notice my work—he was particularly opposed to anything new or progressive—but because it was a pertinent question. I replied modestly that I didn't know, but it had been lots of fun trying. "Well", he concluded seriously, "I don't know. There are a lot of nuts around here yet."

PSYCHIATRIC SOCIAL WORK IN THE LA SALLE-PERU-OGLESBY JUNIOR COLLEGE *

LILA McNUTT, M.S.S. (Smith)

Director, Bureau of Educational Counsel, La Salle-Peru Township High School and La Salle-Peru-Oglesby Junior College

PSYCHIATRIC social work in the La Salle-Peru-Oglesby Junior College is a part of the program of personnel service of the Bureau of Educational Counsel. The bureau was established in the La Salle-Peru Township High School in September, 1923, and had as its main objective the study of the individual student. Special consideration was given to the study of behavior, the development of personality, and the adjustment of emotional difficulties in the high school students.[1] In 1924 a junior college was established in connection with the high school. A year later, in response to the demand of junior-college students who had had contact with the bureau while in high school, the personnel service was extended to them.

The experiment of doing psychiatric social work with junior-college students has been carried on over a period of three years, paralleling and preceded by two years of psychiatric social work with high-school students. During that time psychiatric social work has been started in various universities also. It seems worth while, therefore, to consider whether there may be conditions peculiar to the junior-college student as compared with high-school or university students.

To outline briefly the approach of the bureau to the prob-

* Read as part of a symposium on "Psychiatric Social Work in the Field of Education" at the annual meeting of the American Association of Psychiatric Social Workers, Memphis, Tennessee, May 2–7, 1928. For the other papers in the symposium, see pages 263–70, 278–88, 289–97, 298–308, of the present number of MENTAL HYGIENE.

1 The work of the bureau is described in a report, *The Bureau of Educational Counsel—A Student Personnel Department* (1923–26), published by the bureau in February, 1927, La Salle, Illinois.

lems of the individual student, the procedure for both high school and junior college is as follows:

Shortly after each student registers, the bureau secretary prepares a face sheet for him, giving his age, his birthplace, the names and occupations of the members of his family, the language or languages spoken in his home, his religion, and the schools he has attended. Personality blanks prepared by the bureau are sent to each instructor for his individual rating of the student and for comments on his personality or behavior. Group psychological tests are made by a psychologist from the Institute for Juvenile Research and the ratings are recorded for the use of the psychiatric social worker. A record of the grades earned in high school is secured. In the high school, physical examinations are made routinely and the findings are kept by the bureau.

With this material at hand, the student is interviewed as to scholarship, personality traits, physical health, hygiene, interests, vocational desires, attitudes, and life plans. All this coördinated information is then scrutinized in a consideration of the maximum development of the student. This consideration, which is shared by the student in the interview, often reveals untapped resources or unfortunate limitations which require adjustments of varying degree. Always during the interview the psychiatric social worker is on the alert for emotional disturbance, and such difficulties as require it are noted for future interviews. Those that are beyond the scope of the psychiatric social worker are referred for further study to the psychologist or the psychiatrist—or both—from the Institute for Juvenile Research. (The Institute for Juvenile Research holds visiting clinics at the school about once a month. The value of this psychological and psychiatric service cannot be overestimated.) In this connection there is no connotation of abnormality or of "salvaging human wreckage". A student comes to the bureau to ask how he can overcome fear of the dark, how to get over sensitiveness, or how further to develop positive traits, as naturally as he comes to ask for a part-time or vacation job. The bureau is free from any restrictive element of officialdom. The psychological and psychiatric studies are accepted as part of the school service.

The function of the worker through the interview, then, is (1) to complete the picture of the student at a given time; (2) to reveal to the student all his possibilities; (3) to stimulate him to a realization of the maximum of his possibilities; (4) to guide him along educational, vocational, health, social, and ethical lines; and (5) to observe, recognize, and forestall incipient mental-hygiene problems. Mental-hygiene principles are applied throughout the discussion, but the techniques of the psychiatric social worker are essential in the last function listed.

Many of the students are apparently developing along fairly normal lines. A casual observer would consider the entire group an unusually wholesome one, probably. But a positive, constructive program in mental hygiene includes a study of such seemingly normal individuals. After a talk on mental-hygiene principles directed according to the findings about the student, he is left with an explanation of the purpose of the bureau, and an invitation to return at any time. Others may require frequent and continued interviews, further psychiatric study, and intensive case-work, extending to other members of the family or the community.

Up to the time of the initial interview, the procedure seems to serve equally well for study of the high-school or the junior-college student. At this point—the time of sharing with the student the consideration of the data on himself—the psychiatric social worker is aware of a difference between high-school and junior-college students that calls for a difference in technique. It is assumed that there might also be a difference in techniques required between junior-college and regular-university students. The following points relating to junior-college students are presented for consideration: (1) As compared with high-school students, the group is from one to eight years older, considering the age range from high-school freshmen to sophomore college students. (2) Though still in the formative period, the group is for the most part past the period of ill-defined physical and spiritual incoördinations of the adolescent high-school youth. (3) The group has dropped from the familiar high-school circle and the exalted position of senior to the unfamiliar environment of the first year in junior college. This entrance upon a new phase of

life takes place in their home town, unattended by formality. The student has not the special sense of freedom or the special attention brought about by departure from home to give an added sense of importance. (4) The group is made up of individuals drawn from a home type of people. Either the parents lack aggressiveness, are timid and retiring, unwilling to loose the tie that binds the student to them, or the student is unwilling to adventure to a strange school. In some cases financial considerations may be a factor in determining the choice of a school, but in any case the possibility of incomplete emancipation at this age must have special consideration. (Of the 97 students in the La Salle-Peru-Oglesby Junior College, 66 are from the local city, and of the rest, all but three come from towns within a radius of thirty-five miles.) (5) The members of the group, because they must remain at home, must compare themselves with those of their previous high-school mates who have—in their minds—the distinction of new fields to conquer in other territories—*i.e.*, universities. (6) The group is a small one, and individual differences stand out prominently. Students with special interests must either give them up or work alone. They cannot find a group of kindred spirits to join in the expression of these interests. (7) In this particular junior college there is the advantage of personality studies of four or five years' duration, made during the high-school period, of such students as have entered from the local high school.

It will be observed that these factors are not, in the main, especially conducive to any particular type of psychiatric problem, but some of them condition the kind of adjustment that it is possible to make. The greater maturity of the group as compared with high-school students makes for greater stability and greater resistance. The junior-college student can synthesize and coördinate the factors of personal relationships and is better able to use them as a means to growth and happiness than the high-school student. He has greater control over his environment than has his younger high-school brother, who is apt to be more subservient to parental demands. The high-school student is too much absorbed in his own changing ideas and feelings to make a plan for the integration of his personality. The junior-college stu-

dent is starting formal courses in psychology, philosophy, and ethics. He sees himself as a part of the social order. He views himself and his problems in a more objective way than is possible for the high-school student, who has not this general insight. (A year ago a course in the psychology of personality was given by Miss Olson, former director of the Bureau of Educational Counsel. This proved effective in helping the student to understand his own problems and those of his fellows.) The junior-college student is past the first curve of developing adulthood, yet he still has the personality consciousness or awareness of adolescence. Psychiatric principles make an experimental appeal. He is still sufficiently flexible so that unhealthy personality traits and undesirable emotional habits can be attacked with the hope of eradicating them successfully. The maladjustments are apt to be of recent origin and are relatively simple.

The peculiar advantages of mental hygiene in the junior college which have both a general and a specific effect upon the student and make work with him through the school especially effective are (1) that the school is largely the sphere of his activity, and (2) that the sources of his difficulties and the resources for working them out are to be found within a relatively small area. Many defects in personality make-up are the result of factors that have conditioned the development of the individual from infancy onward. As the junior-college student is in his home setting, such causative factors can be uncovered more easily in his case than in that of the regular-university student. His family relationships and his family and development history are at the hand of the psychiatric social worker.

In junior college the student is nearing the time when he must choose a vocation in life, and the school has information about him that indicates his interests and his abilities. Guidance based upon a psychiatric understanding of the problems to be faced can do much to steer him through his university course or into work. The case of one junior-college girl may be illustrative. Through great persistence, a girl of less than average mentality graduated from high school after several repetitions and entered junior college with a driving ambition to be a teacher. She failed to get credits in her first year of

college, so took the teachers' examinations, which she also failed. She returned to repeat the junior-college work in a further effort to secure a teacher's certificate. She was diffident and had a feeling of inferiority based on actual inferiority. Steering her away from teaching seemed the thing to do to prevent the development of the psychiatric problem that seemed imminent should she enter a field in which she could be nothing but a failure. This in no way describes the work done in steering her to other avenues of employment more satisfactory for one of her endowment.

Junior-college students are arriving at an age when their sex interests are changing from a general ill-defined feeling to a more directed interest. Most of their social contacts are made in and about the school circle. Guidance at this time, based upon trained insight into the personality of the student rather than upon sentimental considerations, has proved through three years of experimentation to be of value to some of the students.

Students are in close proximity to the faculty, the grade schools, and home situations. It is easy to correlate the information of various phases of their activities. Reports from all the teachers are helpful in locating and treating the problems that arise. For instance, in the case of one student, the consistent personality traits checked by five instructors, coupled with the intelligence rating, led to the suspicion of a psychiatric problem before the girl was seen. An interview with the girl substantiated the suspicion. A psychiatric history was secured and the girl was referred to the psychiatrist. The solution of her problem has afforded interest during the winter both to the girl and to the psychiatrist, as well as to those who have watched her develop from a repressed, retiring, dull, diffident girl to one who goes about with some assurance and is able to take the initiative and to realize accomplishments consistent with her superior mentality.

Teachers who have to deal with the students come to recognize symptoms through trends in the work and refer those who need it to the bureau for help. For example, a junior-college freshman, who not only talks with a stutter, but writes with one, was discovered by an instructor; again, a boy who made unusual and suggestive associations in an association

test in a psychology class was referred by the psychology teacher to the bureau and eventually to the psychiatrist and was found to be having conflict over emancipation from his mother.

Through assistance in the observation of problems and the carrying out of psychiatric recommendations, the instructors apparently gain a broader conception of the nature of education. The worker was interested to hear what a teacher had to say about a boy with a fighting attitude to whom, because of her unusual contact with him, she is doling out psychiatric pills. When asked what he was doing in algebra, she said, "Well, he is not doing excellent work, but", quite complacently, "his grades will come along all right when his attitude is straightened out."

A consciousness that these problems can be cared for, and must be if the student is going to function properly, reaches further than the school or the immediate need of the student. The teacher has a new feeling of responsibility for the student as a person who is to continue life into a future detached from the school. After the unfortunate endings of two administrative discipline problems in which two girls withdrew from school, the dean said reflectively, "Now, actually, what has school education contributed to the solution of those girls' problems? They'll have to go on without the support of probably the only place that could give them help"—a statement typical of the awakening consciousness that these problems can be cared for, and that the sole aim of education is not to transplant a certain fund of information from instructor and books to student without reference to that student's particular needs or the effect that such information may have upon him.

The keynote of psychiatric work in the junior college is not to bring a few abnormals back to "normalcy", but to supplement and permeate the educational system so that when the junior-college student is ready to go on to the university or to take up his vocation, he will have some insight into his opportunity as an individual not only "to live, but to live well", intellectually, physically, and emotionally.

A HIGH-SCHOOL DEMONSTRATION CLINIC *

MARGARET MOFFIT PLATNER, M.S.S. (Smith)
Chief Psychiatric Social Worker, Illinois Society for Mental Hygiene

IN carrying out its present policy of education through demonstration of the need for preventive mental-health work in Illinois and methods of meeting this need, the Illinois Society for Mental Hygiene was glad to comply with a request from the Chicago Board of Education for help with its problems. A survey of the resources available for the study and treatment of emotional and mental problems of public-school children showed that, with the exception of the school board's department for scholarship tests for promotion, demotion, and placement in special classes, the only opportunities for complete expert study were in large central community clinics, which are overcrowded at all times and are a great distance from most schools. The Illinois Society, therefore, decided to establish a mental-health unit in one school and to experiment in methods of coördinating its work with the activities and faculty of the school. It hoped eventually to be able to expand to other types of schools in the same district.

The first plan was to place a unit in a grammar school, but as the staff for conducting the work was small, it was thought best to establish the unit in a high school. There it was felt that the simpler problems, such as intellectual deficiency, would have been eliminated, with the result that the volume of work would be lessened and the problems to be dealt with would be more clearly those of behavior. Another consideration that influenced the selection was that the period of adolescence brings many new situations for the individual

* Read as part of a symposium on "Psychiatric Social Work in the Field of Education" at the annual meeting of the American Association of Psychiatric Social Workers, Memphis, Tennessee, May 2–7, 1928. For the other papers in the symposium, see pages 263–70, 271–77, 289–97, 298–308, of the present number of MENTAL HYGIENE.

to face, and with students of this age effective demonstration work might be done. The director hoped that the study would bring to light sufficient evidence to convince the board of education that the establishment of mental-health study and treatment as a routine in the primary grades would not only be of material aid to the pupils and teachers in those grades, but would also be a sound economic investment in that it would filter out many students not suitable for instruction in the secondary academic schools and would point the way to the establishment of a type of secondary instruction that would bring profitable returns instead of disappointment and needless suffering.

Lake View High School was selected for this demonstration because it was thought that in its particular neighborhood there would be found a good average group of students coming from Americanized families with whom contacts could be made easily and treatment effectively carried out. This special school has about 2,500 pupils enrolled and 1,000 additional in two branch schools.

To do away with any ill effects that might have been caused by the term "mental-health clinic", the principal of the high school and the director of the society decided upon the name "Advisory Council for Students" for the unit. The psychiatric social worker was designated as "student counselor", and the psychiatrist was known as "doctor". This terminology involved little if any stigma for the students referred. The teachers were told that the unit did not want to imply that the students were pathological, but that it did want to prevent mental and emotional disturbances and to foster reactions indicative of mental health. Thus, by preventing difficulties at the source, it hoped to reduce the number of socially maladjusted persons in the community. As the clinic could not possibly make a routine study of all students and had to take pupils referred by the teachers, it was very necessary to eliminate from the minds of students and parents the conception that the clinic had to do with mental disease. Also, it was desired to have the unit a place where students would feel free to come voluntarily for advice.

At present the clinic is completing its second school year at

the high school. For various reasons the work during 1926 was of only a few months' duration. The council is now made up of two full-time psychiatric social workers, an office secretary, a psychologist who comes two days a week, and a psychiatrist who is in the clinic two half days a week.

Students are referred by principals, teachers, deans, and occasionally parents, and a number come of their own accord for advice. The latter group help to put at ease the group who are referred by others. When the students are told that some of their classmates come voluntarily to the council, they seem to lose the fear that they have been singled out for some special purpose and that the council is a disciplinary agent. They are told that the council is organized to serve them and to help them get as much as possible out of their school work and environment. Also, the fact is stressed that the counselor is not a teacher and that the interview will be confidential. They are made to feel free to discuss problems of any sort. With this preliminary, an interview is held with the student, during which the following points are covered: under family history, data concerning father, mother, and siblings is obtained, and under personal history, education, economic history, habits, interests, plans, religion, and health are discussed. Prior to this interview, inquiry is made of the teachers as to the student's behavior. Often the interview with the pupil is followed by outside visits for additional history. The parents are told that there is always a reason for unusual behavior or failure in school work, and that the council is organized to study the student's personality scientifically in order to get at the cause of his behavior. This policy of explaining the work to the students and their parents has resulted in full coöperation on their part.

If necessary, the student is given psychological examinations which include not only tests for intelligence rating, but also tests to bring out any special abilities or disabilities. During the first year at the school, a complete study was made of all students referred — that is, the social, psychometric, and psychiatric phases of their lives were considered. This was done in order to work out methods and techniques for handling the various problems presented by the pupils. This

year an attempt is being made to classify the students and to deal with their difficulties accordingly. Many of the students are seen by the psychiatrist, but a number are handled by the psychiatric social worker alone. It has been found that many of the problems encountered can be handled without every child going through the whole procedure of the clinic and that much can be done by the psychiatric social worker alone with advice through staff meetings. In order to work out a more efficient functioning of the clinic, a complete study is made only of specially selected cases. Many problems, being those of normal adolescence, are handled by the psychiatric social worker. Also a number of situations arise where the worker acts in an advisory capacity only and does not personally handle the case. It is felt that in this way more students can be reached and a more profitable and efficient functioning of the clinic will result.

The reasons given for referring the students have been varied — truancy, personality difficulties, theft, sex delinquency, speech difficulties, and poor scholarship. In a group of 35 referred for poor scholarship, it was found that 9 had I.Q.'s in the 90's and 19 had I.Q.'s of 100 or over. In these cases the cause of the poor work was found to be due to some social or emotional maladjustment.

Certain students' problems can be disposed of in one interview, although many need and receive intensive social treatment. Study and treatment of the student takes into consideration not only school adjustments, but also the recreational, social, and economic phases of their lives. Students' problems are often related to mental-hygiene problems of other members of the family. For this reason a complete mental-hygiene study of the family is made and treatment is carried on accordingly. In school adjustment the teachers often have renewed interest in the students when facts about their personal lives are disclosed. Intensive social work is carried on, emphasis being placed on the total personality of the individual. The worker discusses the council's recommendations with the teachers interested, pointing out various ways in which they can be of assistance in helping the student make an adjustment. In the intensive cases, the social worker

keeps very closely in touch with the student's teachers and occasionally arranges small staff meetings or conferences on difficult problems. In this way, through discussion of the problems of the individual students, mental-hygiene principles are conveyed to the teachers.

In addition to the actual social case-work, talks have been arranged for the faculty, and books have been recommended to them for reading. In a number of cases they have asked advice concerning their own personal and family problems. The possibilities that this work has for the teachers is demonstrated by the success of Dr. Alfred Adler in Vienna, who visited the council when in Chicago in 1927 and talked to the faculty about his own work. Talks have been given by the psychiatrist and the psychiatric social workers at the request of the normal school, deans' clubs, principals' clubs, and clubs of representative students. It is felt that when these groups realize the benefit to be derived from a study of each child in order to determine his emotional and social needs and his abilities as he passes through the school system, they will undoubtedly be able to arouse public opinion and exert their influence in installing such work permanently in the schools under the direction of the board of education.

As already stated, the aim of this demonstration has been to experiment in the development of practical methods of instituting mental hygiene in the Chicago schools. The services offered and the make-up of the unit are the standard ones of all approved child-guidance clinics. The unique features of this experiment are the adaptation of them to the local schools, and the establishment of a unit in a school building to cover schools in each district of the city rather than in a separate centralized location. The work has been increased to cover a limited number of students in one grammar school in the same neighborhood, in addition to the one high school and the two branch high schools. The demand for the work on the part of parents, principals, and teachers is increasing. The cost of establishing mental hygiene in the schools need not be great. Psychiatric social workers could be placed in various school districts, and a psychologist and psychiatrist could cover a number of schools as needed.

The rôle of the visiting teacher in this work is important and should be considered from the point of view of general economy also. In schools where the visiting teacher serves as a social case-worker, her relation to the unit would be similar to that of the outside social worker's to a community mental-hygiene clinic. She would secure from the clinic expert study and continued advise on students whom she felt would benefit by it, but she herself would carry out the home and other social adjustments of the student. At the same time, certain students would need the expert service of the clinic in their social life, and this would be dealt with entirely by the psychiatric social worker. The psychiatric social worker would have a limited number of *intensive* cases, in which she would carry out all social and educational adjustments directly with the parents and educators, as well as *advisory* cases in which the visiting teacher, in her function of social case-worker, would carry on the social work, the psychiatric social worker advising her in the matter of obtaining data on behavior, interpreting the recommendations of the psychiatrist, and giving her suggestions as to social treatment. Such a plan would not only dovetail the unit work most advantageously with the present resources of the school system, but would help to make more effective the work of the visiting teachers and would result in a more economical functioning of the clinic.

In order to illustrate the various types of work carried on by the council, three case histories are appended. The first is one of long-time supervision, the second is a case studied by the psychiatric social worker alone, and the third, one studied by the psychiatric social worker and the psychiatrist.

Case 1.—Robert was one of the first students to be referred when mental-hygiene work was started at the school. He was fourteen years, eight months of age, a second-year student, was doing very poor school work, and was listless and indifferent in his classes. Because he was quiet, timid, and slow in his responses, he was not well liked by his classmates. Several teachers had advised him to leave school and take a job, telling him that he could never get much farther in school.

His parents were both born in Switzerland. The father

was a cook in a downtown club and was seldom at home when Robert was there. The mother, a friendly, coöperative woman, was very much interested in her son's welfare and disappointed over his failure to make good in school. She said that Robert, who was the oldest of three children, had had a normal birth and development, but had been growing very rapidly and had a poor appetite. At the suggestion of friends she had taken him to a doctor, whose advice had been, "Leave him alone. Give him time and he will get there." When at home, Robert spent most of his time reading, seldom mixing with the boys in his neighborhood. A writer connected with an extension university roomed with the family, and Robert had access to his library.

The psychologist found him to be an alert, coöperative boy with high rating in all of the tests given him. An intelligence test showed him to have a mental age three years in advance of his chronological age. According to the Stenquist test, he also had good mechanical ability.

When the psychiatrist examined him, the report stated that the boy was undersized and that he apparently took very little exercise. When he attempted to play ball with the students, they had shown that they did not want him, so he gradually stopped his only form of exercise. He had no feeling of real inferiority in regard to his physical activities, but he said that the boys teased him a great deal. He countered this by saying that he knew more about books than they did. Much of the time he spent in daydreaming, usually about successes in business and physical adventure.

After the examination his teachers were told about the findings and were urged to have patience with him and to encourage him as much as possible. The parents were given the same advice. His need for physical exercise was impressed upon them. It was suggested that he have a complete rest during the summer months, in a boys' camp if possible. As the parents could not finance this type of recreation, he was put in touch with the Boy Scouts and was able to have a vacation of several weeks in their camp.

The next year his new teachers were interested in him, and he was seen from time to time and encouraged in his work.

His mother was instructed to aid him in making outside contacts. That winter he did good work in architectural drawing and turned out plates of excellent grade. In the spring he was found to be slumping in his work, so special study periods were arranged for him in the office of the council. His family bought him a bicycle, and he began to take Saturday trips with boys who lived in his neighborhood. Toward the latter part of that year he was encouraged to take a delivery job for two hours after school. This prevented him from burying himself in books and gave him good exercise with an opportunity to be among people. This job be continued until he finished school. On Sundays he sometimes went with a bicycle club into the country for all-day rides. When asked actually to become a member of this club, he was very much pleased, telling his mother that the boys had called him "a regular kid".

A gradual improvement, physical, mental, and scholastic, was noted throughout the remaining months of his high-school career. The last few months intensive supervision was not necessary, although the council stood back of him and, when necessary, gave him understanding encouragement.

Last semester he graduated, and at present he is working. In the fall he plans to enter a technical college. This boy is considered decidedly worth-while material, and it is felt that had not the council encouraged and guided him through his high-school course, he would probably have been sent out to work with only one year of high-school work to his credit, handicapped by a sense of failure.

Case 2.—Mary, aged seventeen, a 3B student, was referred to the council by the principal, who stated that her work was poor and that she seemed to be losing interest in things. She was attractive and friendly, but very sensitive.

In the first interview with her the psychiatric social worker learned that her mother, a member of a distinguished family, had married a man considered her inferior socially. A year and a half after Mary's birth, the mother got a divorce because her parents so heartily disapproved of the marriage. Nothing has been heard of the father since that time. Shortly afterwards the mother married again, this time a man who

turned out to be worthless. This second marriage irritated the parents to such an extent that they disowned her. Both parents died before a reconciliation could be effected. The stepfather legally adopted Mary at her mother's request. Business difficulties developed, and he took his family from one part of the country to another, during which time Mary was given a smattering of an elementary-school education.

A few years ago the mother died, and almost immediately the stepfather married a low-grade woman who drank to excess. Mary lived with them as long as possible, but finally could not stand the conditions and left home, renting a room and securing a job as a waitress. Shortly before the beginning of the semester in which she was referred, some church workers became interested in her and urged her to return to school. They found a place for her with a man who had an invalid wife. Her duties were to care for the small apartment outside of school hours. The situation was difficult in that the invalid was inclined to be too exacting with a girl of Mary's temperament. Mary was full of fun, liked to have a good time, and enjoyed being with young people. In the close quarters of the four-room apartment, it was impossible for her to have young people about; her fun-loving nature was being smothered, and she becoming more dissatisfied every day.

It was at this point that she was referred to the counselor.

On the Stanford-Binet test, she had an I.Q. of 104.

Inquiry revealed the fact that the stepfather's parents were substantial New England people with high ideals. They were greatly disappointed in Mary's stepfather. He was the only son and considered the black sheep of the family. When notified of the situation, they seemed more than happy to do what they could for Mary and suggested that she spend the summer with them. This will be arranged and very likely she will make a permanent place for herself with them. In the meantime the pastor of her church has been canvassing his congregation in an effort to find a suitable home for her until the close of the school year. He thinks that he has located such a home, where Mary will have contact with a stable, understanding woman. In this home she will have a

room of her own and will be able to entertain young people occasionally.

Mary seemed to need some one in whom she could confide and who would aid her in rearranging her life. Only three interviews have been held with the girl by the counselor, yet she is already showing interest in her work and her whole attitude has changed.

Case 3.—Dorothy, a girl with unusual musical ability, was a problem at school because of frequent fainting attacks. The fainting occurred usually in her musical class or immediately after it. In other classes the teachers reported that she would put her head down on the desk or leave the room, but never faint. She had a great deal of attention from the other girls, who always watched her and helped her up and down the stairs.

She was referred to the council for study and was found to be an attractive girl, nicely dressed and well mannered. She was of average intelligence, having an I.Q. of 103. She was thirteen years of age, born in this country of Serbian parentage. She had one sister, aged twelve, who attended the same high school. Dorothy's father had been divorced by her mother when the child was seven years of age. After this, Dorothy influenced her mother to marry a man whom she knew and who was very kind to her.

The mother told of changes in Dorothy's behavior since she had entered high school. Until that time she had been docile and obedient at home and affectionate toward all members of the family. Soon after entering high school, she had become sullen and rude to the entire family. She was especially unpleasant to her sister, often slapping her if she displeased her.

Dorothy was an honor student the first semester, but her grades had been getting poorer as the year progressed. When she was interviewed by the social worker, she said that she was unable to think well, and showed considerable apprehension regarding her work. She told of her admiration for her music teacher and her feeling that her parents did not understand her. She said that she did not love her parents, but

when asked how she behaved at home, she replied "Oh, I'm not mean."

She was interviewed by the psychiatrist, who felt that she was going through a reappraisal stage. He discussed with Dorothy her ambivalent feelings toward her parents and helped clear her attitudes in her own mind. A physical examination was recommended.

The mother told the counselor that Dorothy had been her old self at home beginning with the day that she had been interviewed by the counselor and the psychiatrist. There has been no complaint of her behavior at home since that time and fainting at school has not recurred. This student needed to objectify her own behavior and have some of her feelings interpreted for her. This was done, and all her behavior difficulties disappeared.

A MENTAL-HYGIENE PROGRAM IN GRADE SCHOOLS *

ELIZABETH ALLEN

Executive Secretary, Mental Hygiene Committee, Onondaga Health Association, Syracuse, New York

THERE are many aspects of a mental-hygiene program in the grade schools that present interesting and perplexing problems to the psychiatric social worker. Problems of organization, of policy, and of relationship to the school nurse, to the truant officer, or to outside social agencies are all fertile subjects for discussion and experiment. This paper aims merely to suggest some of the problems the psychiatric worker meets in adjusting herself to the school system and to school-teachers, and her rôle in handling the various types of children's problems that are referred to her for advice and treatment.

When a psychiatric worker begins a mental-hygiene program in the schools, her first problem is one of adjustment to the point of view of the school-teacher. This is often radically different from her own. The emotional satisfactions and relationships in a social worker's job differ greatly from those in a teacher's. From the emphasis that many teachers place on the authoritative aspects of their work, in their relationships both to their children and to their supervisors, one feels that to many teachers authority plays an important and significant rôle. In watching teachers, one is often impressed by their apprehension of the supervision of principal or superintendent and their acceptance of his authority. Sometimes their only protest against an over-authoritative attitude on the part of their supervisors is a stressing of their authority in the classroom. While a teacher may have

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a feeling of security as a unit in an organization that gives her backing by its symbolism of authority, she often feels very insecure in her own classroom. In the organization necessitated by a large school system, she has increasingly fewer opportunities for initiative or self-expression. School systems have worked out certain accepted yardsticks to test the teacher's success or failure, and by these she is constantly checked both in her own mind and that of her supervisor. Positive, concrete evidence of her success as a teacher lies chiefly in a quiet, orderly schoolroom and in the fact that a large percentage of her children pass the grade. The children who destroy these evidences of her success naturally make her feel insecure. It is with them that she uses her authority.

In contrast to the teaching profession, psychiatric social work has little opportunity for the use of authority. The social worker, it has been suggested, finds compensation in her profession for her own feelings of inadequacy, due often to her inability to adjust her own family relationships. She, therefore, turns to a profession that has as its main interest helping others solve successfully their family relationships. The social worker gains her satisfactions in her job not from its authoritative attitudes, but in the assistance she gives to others who are perhaps more badly adjusted than herself. In case-work there are, as yet, no accurate or accepted yardsticks, such as examinations, which will check up her failures. Her case-work technique cannot be accurately tested, and standards of success and failure are so variable that it is impossible to judge the degree of adjustment she has been able to work out for a client. Case-work failures can often be ascribed to causes and forces outside of the case-worker's own technique, and the case-worker, therefore, may gain a partial security against criticism both from her supervisor and from herself. Her job offers her many opportunities for initiative and self-expression in her relationships with her clients, with practically no emphasis on authority.

The adjustment of the psychiatric worker's point of view to that of the teacher is further complicated by the fact that the teacher works with individuals in a group, whereas the social worker handles them separately. If the social worker

had her case load of forty cases in one room at the same time, she, too, would be perplexed by their reactions upon one another and by her responsibility to the group rather than to the individual. The teacher who has struggled with an obstreperous youngster for many months sometimes refers him to the psychiatric department with the attitude, "I have done my best—I have tried everything. There is nothing more that can be done in school with him. It isn't right to have him annoy the whole class. If he thinks he can get away with it, the other children will do the same. You must do something with him!" To the teacher with forty children in her classroom it seems unfair to the other thirty-nine children to give this one obstreperous boy constant individual attention. She is impressed with the needs of the entire group for which she is responsible.

The psychiatric worker, on the other hand, is apt to see only the needs of the individual child. Sometimes she identifies herself with this protesting, difficult boy who cannot adjust to the teacher's authority, and carries over an attitude of protest on her own part toward the teacher. With her knowledge of the child gained through a psychiatric study of his life history and an interpretation of the mechanisms of his behavior, she sometimes approaches the school-teacher with an attitude of superior knowledge. She realizes the possible seriousness of the child's personality trends. She realizes also the important rôle the teacher or the school situation plays in the child's reactions. She asks for individualization of the child, while the teacher stresses the needs of the whole group of children. When the teacher responds with a lack of understanding or sympathy, the psychiatric worker sometimes responds by working out a plan of treatment for the child of which the teacher has very little understanding or with which she has little connection.

An adjustment between the differing points of view of teacher and psychiatric worker is possible when the teacher realizes that the most hopeful opportunity of changing a child's behavior lies in her own attitudes toward the child. The psychiatric worker should help the teacher gain the satisfaction that comes from adjusting her children's prob-

lems by her own technique and by her own understanding of the behavior reactions of the individual children. Thus the teacher will gain a sense of security in her classroom and lose the feeling that the final solution for the difficult child is to have him removed by the psychiatric worker. This involves most of all helping the teacher to attain an attitude of objectivity toward the children, so that she will not blame herself for her classroom failures or feel that it is her lack of good intentions or effort that has caused an unfavorable reaction in a child. When the teacher can learn to analyze a child's reactions and her own methods of handling them without guilt feelings on her own part, the success of the mental-hygiene program in the schools is assured.

In considering the various types of children's problems that are usually referred to the psychiatric worker, one of the most important and perplexing is that of the so-called "dull-normal" child who is a frequent repeater of grades. School authorities are not always conscious of the emotional problems involved both for the teacher and the child in this constant repetition of grades. The teacher is emotionally disturbed by these dull-normal children who, in spite of her best efforts, fail to make the grade and will, therefore, be checked up against her as grade failures. The child, too, may develop many inferiority feelings from being a constant failure in the classroom. If he becomes a listless day-dreamer who goes through the motions of school routine and causes no trouble, the teacher has little feeling about him except one of pity and a mild protest at having a constant failure in her class. But the dull-normal child who uses truancy or constant incorrigibility to secure the teacher's attention presents a problem that some teachers find a source of perplexing irritation. These are usually the children who are referred to the psychiatric worker for treatment.

One boy studied in our work is a good example of this type of reaction. He was an overgrown lad coming from an unstable family background with a long history of quarreling and frequent changes of home. In school, Charles had been a chronic repeater of grades. At the age of fifteen, in the 5–1 grade, he presented the picture of a typical dull-normal

boy, playing the clown to attract attention and slouching in his seat at the back of the room in a classroom filled with children half his size. With an I.Q. of 78, he was hardly material for one of our ungraded classes, already overcrowded with children of much lower mental ability. Charles had superior mechanical ability, but was not eligible for the pre-vocational class because of his inability to reach the 7–1 grade. Charles played truant constantly. Upon the psychiatrist's advice, he was put finally into an ungraded class with special handwork, but the mischief had already been done. Charles had never succeeded in school, and he had no feeling of satisfaction inside of the school world. This he got outside, gathering wood and coal on the railroad tracks for his grandmother and hanging around poolrooms with a gang of older boys. To the school Charles was a difficult problem. He was constantly reported for truancy, constantly followed by the truant officer, and was frequently in the police court. When he could leave school at the age of sixteen, Charles secured a job at $20 a week. The community gave its approval to his muscular strength and ability in a a way that the school had never been able to do. Moreover, in his school life he has developed attitudes of shiftlessness and indifference that may cause him in the future to become a serious social problem.

The possibilities for the case-worker of adjusting these dull-normal children are rather limited unless there are special classes and curricula adapted to their intellectual capacities. They will continue to swell the ranks of truants and incorrigibles as long as they are chronic failures in the ordinary classroom with no opportunities for a feeling of success. The psychiatric worker in the schools should use her case material as a means of bringing to the attention of educators the need of developing more special classes and a less rigid school curriculum fitted to the needs of these children. This, as well as trying to adjust the individual child, should be part of the psychiatric worker's program.

Many other types of problems besides those presented by the feebleminded or dull-normal child are referred to the psychiatric worker. One of the most interesting is the person-

ality difficulties that many children manifest on first entering school or kindergarten. The child leaves the security of home—where all faces are familiar, where he is accustomed to the types of reaction of mother, brother, and sister—for a vague, unfamiliar building with a strange mother substitute and some forty-odd children in his class. He has been accustomed to a large share of the mother's attention. In school, the teacher must divide that attention, not among three or four children, but among forty. The child must adjust to rules which are not altered frequently by a mother's love. These rules are attitudes of a teacher for whom at first the child has no affection.

It is very interesting to watch the first days of school in the kindergarten and 1–1 grade. Some children cry continually for a few days; others begin to assert themselves by fighting with classmates; some immediately aspire to a large part of the teacher's attention by becoming the "teacher's pet"; some sit aloof, shy and self-conscious, showing no interest in the classroom activities. There is no more strategic place than the kindergarten or the first grade for a psychiatric worker to reach children who show these minor behavior difficulties before they become so aggravated and complicated that adjustment is a difficult process.

James, a boy of six, referred to the psychiatric worker, is a good example of this type of problem. The kindergarten teacher reported that for the first day or two he seemed somewhat aloof. On the third day he suddenly said, "I've got to cry!" and proceeded to weep. These spells of weeping became more frequent, and were accompanied by the need of urination and defecation. He refused to join in the children's games or group activities. He could only be quieted and made happy by being allowed to play alone in the sand pile. If the other children came to play with him, he stamped his foot and began to cry. James was an only child. James's mother both brought him to school and called for him, although he had only a short distance to go and no car tracks to cross. She dressed and undressed him, put on his rubbers, buttoned his coat, pulled on his hat. He had never been allowed out of her sight, even to run an errand to the store or go around

the corner to see his grandmother. She often hand-fed him. She allowed him to play with no other children. The family live in one single furnished room, and James's cot is right beside his parents' bed, where his mother can put out her hand to touch him at night to be sure he has not disappeared.

The problem of weaning James away from his mother has been a perplexing one because of her limited mental equipment and her own personality difficulties, which go back to her early childhood experiences. It was found almost impossible to give her any insight into the situation so that she would change her attitudes. Opportunities for helping James lay in school only, and because of the coöperation and understanding of the kindergarten teacher, these have been fairly successful. She paid absolutely no attention to his tears or temper tantrums. She gave him a little extra attention when she tried to get him into group activities by letting him hold her hand in the games. She encouraged his mother to let him put on his own hat and coat and to praise the child for being a big boy instead of a baby. Finally she persuaded the mother to let him play on the street and go home from school alone. His attitude in school has changed and he is apparently making good adjustment to teacher and playmates. Although the home situation cannot be radically altered, the child has learned a healthy reaction to reality in his school life.

The child who changes schools frequently often presents difficulties or problems that are referred to a psychiatric worker. The school system is impressed with the necessity of fitting these children to the curriculum, but is not always conscious of the emotional conflict in the child's mind when he comes into a strange school building where all the other children are acquainted and he must face an unknown teacher and a new group of playmates. The teacher's first reaction to this new child often makes a marked difference in his subsequent behavior. She is perhaps preparing her class for a regents' examination. In the middle of the term enters a new boy who will require a great deal of extra attention before he can be fitted into the rest of the group. The teacher is discouraged at the arrival of this new pupil and sometimes

tells the child so. Teachers have themselves told me of greeting such a pupil in the middle of the term with the remark, "How dare you come into my class just before the end of the term and expect me to get you ready for examination?" or, "You are too dull to do the work of this grade. I don't want you in my class." Later these teachers were honestly surprised when these children played truant or were listless and indifferent in class. Here, again, there is a marked difference in the attitude of the social worker and the teacher to her job. We social workers often protest against our heavy case load, but we usually wail to a coworker or a supervisor. We do not dare tell a client that we are carrying-ing forty cases with ten new ones this month and that we do not want another new case! We would soon lose our clients, as we are backed by no authority such as the school system gives the teacher. The latter is sure of her authoritative rôle with the child and uses this method to protest against the burden of an overcrowded classroom.

In treating children referred to her, the psychiatric worker is confronted with the task of dissociating herself even from the necessary authoritative attitude of the school. If the child identifies her with the truant officer, with the principal who punishes him for bad behavior, or with the place where he is sent because he is incorrigible, the child will carry over to the psychiatric worker much of his unhealthy protest against authority which probably was engendered inside of an unfortunate home background. The psychiatric worker must identify herself with the school in the teacher's mind, but to the child she must be an understanding, objective friend who takes no part in the school discipline. Therein lies a task which requires all of the psychiatric worker's technique and is one of her most perplexing and interesting problems.

The varieties of children's problems that come to the attention of the school psychiatric worker are almost indefinite in number and are indicative of the need of individualizing a child in a large school system which is necessarily much concerned with the problems of masses of children. In planning her program, the psychiatric worker should, therefore, include not only her study and treatment of individual children, but

methods of interesting teachers in the contributions of present-day psychiatry in the field of child behavior. Small group conferences of psychiatrists, psychiatric social workers, and teachers are one of the best methods of stimulating this interest. These conferences should not be lectures given by psychiatrists, but group discussions with suggestions for treatment given both by teachers and psychiatrists. The presentation of the child's history is often an illuminating experience to the teacher who has seen only his behavior reactions in the classroom. In these conferences she gains an appreciation that the child's behavior is largely a response to past experiences and present home situation. The importance of her own rôle and her own emotional attitudes for the child's behavior often stimulates in her keen interest in trying new methods to change that child's behavior patterns. From these case histories the teacher also appreciates that emotional conflicts produce many scholastic failures among her pupils and that, therefore, the mental-hygiene approach has a real contribution to make to her educational methods.

A psychiatric worker within the school has opportunities for service with children that no outside agency such as a clinic can contribute. Children are referred to her with minor behavior difficulties which few schools would ever refer to a psychiatric clinic. She has many opportunities for working out treatment plans for children within the school. She can have frequent natural contacts with child and teacher. Through her case material the teacher can gain an understanding not only of one difficult child, but of the behavior reactions of all the children in her classroom. The teacher with this insight can develop happy, wholesome personality reactions with her children and be an important asset in carrying on a successful mental-hygiene program.

THE PSYCHIATRIC SOCIAL WORKER AND THE NURSERY SCHOOL *

GRACE CORWIN RADEMACHER, M.S.S. (Smith)

Psychiatric Social Worker, The Behavior Clinic, The Cleveland Day Nursery and Free Kindergarten Association

NURSERY schools vary so much one from another that it may be advisable to define briefly what is understood by the term in this paper. A nursery school is an environment especially arranged to further the all-around development of the child from seventeen or eighteen months to four or sometimes five years of age. According to Miss May Hill,[1] "many workers in the field of nursery-school education are coming to feel that the term 'nursery school' should be delimited to apply to those groups that are organized and staffed to carry through (1) a detailed program of physical health, (2) a program of mental health, and (3) a program of parental education". Nursery schools lack the standardization that is prevalent in all other forms of education. This to a certain extent is probably desirable, yet it necessitates familiarity with each nursery school in addition to a knowledge of the movement as a whole. Nursery schools vary as to the upper and lower ages of children considered eligible; they vary as to the number of children enrolled from as low as eight to as high as thirty-five or even more; they vary as to curriculum, if their daily program may be given such a formal name; they differ, too, as to policy toward fostering group activities, in extent of health and habit training, and in facilities for sharing in experimental programs. Thus far nursery schools have been tied up with one or more secondary purposes, such

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[1] See *The Nursery School and Parental Education*, by May Hill, in The Sixth Yearbook of the National Education Association, Department of Elementary School Principals. Washington: National Education Association, 1928. Chapter 2, pp. 145–61.

as training for motherhood, parental education, research in child development, student training, or have served as demonstration centers or been associated with philanthropic ventures such as the day nursery. While these interests are all worth while, it is sometimes difficult to arrive at the proper balance between these valuable by-products of the nursery school and its primary function—the all-around development of the child.

Here in Cleveland the position of psychiatric social worker for the Day Nursery Association has included work in two nursery schools—Gowan and Samantha Hannah. The association itself embraces five day nurseries, three kindergartens, the two nursery schools, a summer nursery, and a behavior clinic, and is closely affiliated with the nursery-kindergarten-primary department of Western Reserve University. The two nursery schools are financed by the Day Nursery Association, but are staffed and operated under the direction of the training department. This arrangement necessitates the adjustment of the nursery-school program to the special needs of both university and philanthropy. Their association with the university means that there must be a place where student teachers may practice and suitable arrangements for their supervision. On the other hand, the fact that they are housed with and are a part of a day nursery determines the social stratum from which their children come and, because of the broken-home prerequisite for admission to the day nursery, determines also to a large extent the hours and fees, and means that very elemental educational work with the parents is necessary. Such a program of parental education is another interest to be differentiated from direct work with the children. Organized scientific research *per se,* although ever in mind, has not as yet influenced the program to any extent.

Two years ago the Day Nursery Association added a behavior clinic to its equipment, to study behavior and personality problems in the various nursery groups and to help with the education of the parents. The clinic has on its staff a part-time psychiatrist and medical examiner, a part-time psychologist, a full-time psychiatric social worker, and a part-time secretary. Although this unit has not confined itself to the nursery schools, but has studied children from the asso-

ciation's kindergartens and from the day nurseries proper, which include boys and girls up to fourteen, the discussion in this paper will be limited to the educational aspects of mental-hygiene principles and psychiatric social work as applied to the nursery school. The usual case-study method has been employed even with these younger children. For more details of the clinic's organization and other functions, the reader is referred to a previous article.[1]

In evaluating psychiatric work from the point of view of education in connection with nursery schools, let us consider some of the possible channels of education that may be utilized to advantage by clinic or psychiatric social worker. It has not been customary for the psychiatric social worker or psychiatrist or psychologist actually to step in and handle the child. Consequently the clinic's task resolves itself into imparting or correcting information, changing attitudes, or developing techniques in a second person, usually parent or teacher, who will in turn manipulate the child according to the more acceptable rules of child training. These channels of education loosely divide themselves into three groups: (1) methods that tend to stimulate the nursery-school staff's own knowledge on the subject; (2) methods that are brought to bear directly on the parent; and (3) methods intended to secure the coöperation, raise the standards, or improve the technique of other organizations that come into contact with the child or the family from some other angle. Let us consider first those methods that may be used to stimulate the nursery-school staff's own knowledge on the subject. Five channels may be consciously employed to reach this group. The first and most informal is actual observation by the clinic staff in the nursery school, followed by a discussion with the director of incidents as they arise. Second, the nursery director should always be invited to be present at the staff conference, not only so that she may contribute information as to the child's behavior in the nursery school, but in order that she may see the child in his complete medico-social setting and familiarize herself with its psychological and psychiatric aspects. Third, a formal series of related lectures on

[1] "A Behavior Clinic", by Grace C. Rademacher. *Welfare Magazine*, Vol. 17, pp. 38–48, October, 1926.

child training has been given by the psychiatrist for the nursery superintendents and their assistants. This method in a somewhat more elaborate form could be employed with equal success with the nursery-school directors and teachers. Fourth, the psychologist and psychiatric social worker have been giving courses in the Graduate School of Western Reserve University for advanced students and teachers on mental tests for children and case studies. Fifth, probably our most direct and successful channel for education has been the forming of so-called educational-psychiatric seminars. Membership is limited to the faculty of the nursery-primary-kindergarten department, the behavior-clinic staff, an interested nutrition worker, and a second psychiatrist. Meetings are held at the homes of members one evening each month from October to June. Each member is responsible for presenting a paper, which is followed by an open discussion. Some of the topics that have been discussed at these meetings include:

A. "An Evaluation of the Nursery School", by a director of one of them.
B. "Tests of Children Under School Age", by the clinic's psychologist.
C. "Health Problems in the Kindergarten and Nursery School", by the nutrition worker.
D. "Parental Education", by a director of one of the nursery schools.
E. "Cultivating the Appetite", by the clinic's psychiatrist.

These seminars have created considerable interest and have proven a common meeting ground for all those who are working toward the well-rounded development of the child.

Let us now consider our second division—*i.e.*, those methods that are directed toward the parent. Here the approach may be either individual or through a group. The individual conference by the nursery-school director with the mother or father is the natural and easier approach. In any event all other methods should be supplemented by such conferences. Mothers' clubs have been organized by both the directors here. These take the form of a supper at the school, followed either

by a ten-minute talk by the psychiatric social worker, camp director, or some outside person, or by a demonstration of proper clothing, cooking, correct way to give a bath, and so forth; after which the program is concluded with some simple form of entertainment such as grab bag, exhibition dance, stereopticon slides of nursery-school children showing the day's program, or the like. Another method of arousing the parents' interest has been employed by one of the directors who has had the mother mark daily on a wall chart as she leaves the child certain information covering such points as number of hours' slept, breakfast menu, elimination, disposition, and so forth. This has as much value as an educational measure for the parent as it has in helping the nursery school to deal intelligently with the child. Some of the more superior mothers who are able to read have been given simple pamphlets on habit training. In some nursery schools the enrollment of the child is contingent upon the parent's spending a specified number of hours in observation at the nursery school—another nursery school than that in which she has her child might even be preferable—and in still other localities the mother is required to spend a certain amount of time each week actually assisting in the work of the nursery school or in keeping detailed records. As no nursery school keeps the child for a twenty-four-hour program, it is evident that if its work is to be at all far-reaching, with a minimum of wasted effort, the underlying principles of the nursery school must be carried over to the home through some sort of parental education.

Our third important division—*i.e.*, those methods intended to secure the coöperation, raise the standards, or improve the technique of other organizations which come in contact with the child or family—have been worked out to a large extent indirectly through the very proximity of demonstration nursery school and day nursery. Our objectives have been disseminated also by always inviting to the staff conference the nursery superintendent and her assistants, the outside case-worker, and representatives of other interested organizations, as well as the director of the nursery school. After the meeting each is sent a full typewritten report of the study, together with an analysis of the difficulties and suggestions

for treatment, including the detailing of responsibility for carrying it out. This is a roundabout and slow method of education, but nevertheless an important one. The day nursery in particular, having its origin in philanthropy and its program more or less determined by the needs of the working mother and caring for the large number of children that it does, has not always been in a position to apply at once the latest developments in child psychology and education. However, its association with the nursery school is bound to focus its attention on the proper development of the emotional life of the child as well as on his physical health and well-being.

Psychiatry itself can make one important contribution to the whole nursery-school concept by keeping before the minds of the directors and teachers something of the psychoanalytical interpretation of the nursery school. Coming to the nursery school is the child's first step outside of the protective atmosphere of the home. Here he at once becomes John X., rather than Mrs. X.'s baby or Lizzie X.'s baby brother. The teacher becomes the parent surrogate, usually a mother substitute, but in so far as she comes to represent authority to the child, she also takes on certain father aspects. Another big difference is that John, now among his peers, discovers a number of similar competitors striving for the same adult's approval. Nursery schools are rather consciously striving for objectivity in their technique with children. Much of their success is doubtless due to this ability to deal with each child in an entirely unemotional manner. But in their judicious avoidance of the maudlin and the sentimental, which is so ready to crop up where babies are concerned, have they perhaps been over-zealous in their striving for objectivity? Are we as mental-hygienists prepared to say as yet that the toddler does not need a tempered amount of emotional expression from the adults who have him in charge? The psychiatric social worker has a place, it seems, in keeping before the directors some of these analytical concepts pertaining to the normal development of the emotional life of the child.

A more intensive type of educational work is possible in the case of children who have been referred to our behavior clinic for special study. Here, if the family is not active with any other case-working agency, the worker has the oppor-

tunity to do all of the case-work. If the family is one that is being carried in coöperation with some other agency, the clinic assumes responsibility with the day nursery and the nursery school for putting into effect the physical, psychological, and psychiatric recommendations, but refers to the other agency the plans to be carried out in the home. We have experienced the usual difficulty in getting nursery-school directors to refer nursery-school children as behavior or personality problems. This is chiefly because a nursery-school director has had special training in meeting incipient problems herself, but also because problems are more difficult to recognize in the two- to four-year-old, while the more flagrant asocial behavior of older boys and girls captures the attention of the person in charge because of its annoying character. Mr. E. K. Wickman,[1] in a special study at the Milford School, Cleveland, Ohio, demonstrated this tendency on the part of teachers to consider as first in importance as problems those children who exhibited definitely asocial behavior, such as stealing, lying, truancy, sex offenses, and so forth, whereas personality difficulties which might have proven equally in need of attention from the mental-hygiene point of view were given last place.

In order to obtain some idea of the type of mental-hygiene education that the psychiatric social worker may need to employ, let us examine briefly a general classification of causative factors which have been outlined by our psychiatrist in his analysis of the problems presented by nursery-school children that the clinic has studied intensively. First are the problems of an organic or hereditary nature, such as inferior stock, psychopathic trends in immediate members of the household, mental deficiency, congenital syphilis, endocrine disorders, malnutrition, and other physical defects of greater or less importance. Next in importance are factors relative to the home, such as prolonged infancy and dependence; faulty home patterns; primitive emotional responses at home and the like; unhealthy early conditioning; unwise forms of home discipline of the irregular and repressive type, with psychological errors such as talking about the child in his presence, "don'ts", threats, bribes, an attitude of apprehension,

[1] *Children's Behavior and Teachers' Attitudes,* by E. K. Wickman. New York: The Commonwealth Fund, 1928.

moralization, unwise attention, overstimulation, the employment of the child as sole love object by the parent, failure of the home to establish regular health habits, and the like. Often the home is lacking not only in proper playthings, but also in proper play space and playmates of the child's own age. Sometimes the causative factors are apparently beyond control, as the loss of love object through the death or absence of the mother; the absence of a wholesome father influence; confusion in the mind of the child resulting from too many disciplinary agents at home, nursery school, and elsewhere, or frequent changes in boarding home, own home, or institutional placement. Occasionally the fact that the child is the largest or smallest in the nursery-school group has been considered important as a clue to his behavior, as have also incipient feelings of inadequacy due to extremely inferior physique. In one instance it was felt that a dull-normal boy of three years and four months who had been in the same nursery school since the age of eighteen months had become saturated with his environment, and his transfer to one of our own kindergartens was accelerated. If these are a fair sampling of the causes of behavior and personality difficulties of nursery-school children, it is apparent that education in mental-hygiene principles has a considerable contribution to make and that the psychiatric social worker has an important place in the program.

The case of one child, Reginald, aged four years and eight months, demonstrates some of the educational methods that may be utilized. Reginald had been in the nursery school two and one-half months when he was referred for clinic study, not because he was a problem in the nursery school, but because his mother complained that she could do nothing with him at home. He would wet himself, never obey, and display temper, and had actually bitten her severely. Examination revealed a well-developed, good-sized lad in fair physical condition except for a history of pyelitis and enuresis. The psychologist found some scattering in his tests and commented that at times he appeared very bright. She gave him a mental age of 4.4 with an I.Q. of 89 on the Stanford-Binet test. His adjustment at the nursery school had been entirely satisfactory. It was noted that, when he was not allowed to do certain

things, he would frequently remark: "I can do that at home." At first he showed some hesitancy in conforming to nursery-school routine, but this quickly disappeared. The home consisted of the mother, twice divorced, her invalid mother, and this child. Any natural outlets to his youthful spirits were checked because he "would annoy grandma". The father and mother had lived together only six weeks. The father was, no doubt, erratic, but the mother interpreted his every act as vulgar, crude, and especially aimed at making her suffer. A five-year-old son by a previous marriage had died just prior to her marriage to Reginald's father. Her own mother had continued to live with her through both of her marital ventures. In fact, she showed definite signs of a marked mother fixation and other psychoneurotic trends, including an over-emphasis upon detail, a passion for cleanliness, and marked suspiciousness. These, together with the presence of the invalid grandmother; the frequent absences of the mother, who was a canvasser, and the consequent supervision of Reginald by a series of maids; the absence of the father; the increased emotional concentration on this child because of the loss of the first; the numerous psychological errors in home training; and the pyelitis and dull-normal intelligence, were thought more than to account for the difficulties of which the mother complained. Treatment naturally assumed the form of working with the mother and with the child in an attempt to bring about a better knowledge and practice of mental-hygiene principles. In addition to an interpretation of the physical and intellectual findings, the mother was given some insight into her own emotional problems and the part played by the grandmother. She was given two leaflets on child training—one on enuresis and one on obedience—and after her perusal of these a pamphlet on the same general subject, together with a sample copy of a magazine dealing with child development. As her interest grew, the psychiatric social worker took her for a morning's observation at the other nursery school of the association. The other school was chosen so that her attention would not be centered on her own child. The methods of handling employed by the director were explained as they occurred. The mother was next encouraged to attend several lectures on child training by

well-known speakers at the local city club. But unfortunately, just as she was responding nicely, Reginald developed another attack of pyelitis and was withdrawn from the nursery school.

In another case—that of Annie, aged three years and eleven months, an extremely pathetic, malnourished, pale child, suspected of being tuberculous, who cried constantly when she was brought to the nursery school after the death of her mother—much of the work along educational lines was done by the psychiatrist with an older sister, of nine years, who had, together with the foreign-speaking father, the responsibility for the care of the younger child. The principal psychiatric difficulty seemed to be due to loss of love object through the mother's death and an attendant feeling of insecurity. This was being constantly aggravated by the older sister whose leave-taking at the nursery school every morning was very emotional, with much embracing and kissing. After she had been given some insight into Annie's feelings and had modified her conduct accordingly, Annie's crying ceased almost at once and within the course of a few days she had begun to take an interest in play equipment, although she still looked sad, seldom spoke, and made no effort to join in the activities of the other children. These examples, though only suggestive, illustrate some of the approaches that can be employed along educational lines in the nursery-school field.

There are no doubt many other channels that can be utilized for educational purposes by psychiatrist and psychiatric social worker in a nursery-school program. Some of these the ingenious worker will discover as she treats individual cases. Advanced technique of a more general nature, of perhaps more universal application, will be worked out as mental hygiene more and more invades the nursery-school field. In the next few years more and more psychiatric social workers, psychologists, and psychiatrists will be turning their attention to treatment and research in this really preventive territory. Prophylaxis here in these formative years should eventually show itself in a lessening of the intensity and frequency of adult maladjustments. The nursery-school movement, in this country at any rate, is, like its charges, still in its infancy, and up to this time has been virtually untouched by mental hygiene and psychiatric social

work. As in its applications elsewhere, there will have to be certain modifications of its technique to meet the demands of a field of education primarily interested in such young children. Her technique in working with adults will stand the worker in good stead in her contacts with teachers and parents. There is no doubt that a mental-health program of some sort has a legitimate place in the nursery-school movement. It may even prove advisable to make a personality study of each child shortly after his admission to a nursery school. Be that as it may, nursery schools are increasing, many children have already been enrolled, numerous training and personality problems are already in existence, and the extent to which assistance in their solution will be given by means of a mental-hygiene program will depend both upon the nursery school's realization of the need for the skills of psychiatrist and psychiatric social worker and upon the psychiatrist's and psychiatric social worker's further discovery of the nursery school as an extremely interesting and vital educational development, suitable for the application and practice of mental hygiene.

THE MEANING OF PSYCHOANALYSIS *

MARTIN W. PECK, M.D.

Instructor in Psychiatry, Harvard University Medical School

THE word psychoanalysis, in the thirty years of its existence, has come to have a place in the vocabulary of all educated people and is not unknown to the man in the street. Unfortunately, such a wide variety of meanings and allusions have developed for the term that it bids fair to become "all things to all men" and to have its real significance obscured. For clear thinking on the subject, some more precise consideration of definitions seems desirable.

Psychoanalysis has three distinct meanings: First, it designates a special system or school of psychology. Second, it refers to a unique and distinctive method of treatment for nervous disorders. Third, it covers an equally distinctive method for research study of the human mind, normal or abnormal.

Historically, the therapeutic side came first. In 1895, Breuer and Freud published their *Studies in Hysteria.* They found that certain hysterical symptoms were removed by bringing to consciousness forgotten experiences which bore a causal relationship. These experiences had occurred in childhood, were "traumatic" in intensity and character, and usually sexual in nature. The investigators believed that the forgetting was purposeful, brought about in order to protect the individual from the painful memories of the experience, and the term *repression* was selected to designate the mechanism. They considered that the symptoms of the patient were disguised expressions of these repressed memories, which had remained as "foreign bodies" in the deeper recesses of the mind. Hypnotism was used at first as a means for bringing hidden memories to the light, and this process, together with a frank facing of the early experience in conversation with

* The substance of lectures given to Harvard Medical Students at the Boston Psychopathic Hospital, March, 1928, as part of a third-year elective course in psychiatry. Reprinted by permission from the *New England Journal of Medicine.*

the physician, plus a discharge of painful emotion (termed "catharsis"), was called psychoanalysis. As the method was perfected, hypnotism was found to be unnecessary, and the process of free association was substituted. It is not the purpose of this paper to review the history of psychoanalysis. Suffice it to say that this first conception was altogether too simple for a general explanation of neurotic symptoms, and marked only a first step in the development of the present psychoanalytic doctrine.

It is not literally correct to speak of psychoanalysis as a system of psychology. Rather does it consist of a body of material, empirically established from observed clinical phenomena, arising in therapeutic procedure. Interpretation of these facts has led to the psychoanalytic hypotheses, which are still fragmentary and somewhat unrelated. Freud himself has deliberately refrained from forming a school of psychology, and has devoted his attention to the development of special topics or lines of thought to which his clinical observations and his reflections have led him. There is nowhere in the literature a systematic presentation of psychoanalytic psychology. An exception may be Rank's *Genetic Psychology*, of recent publication, in which the author, using the material of psychoanalysis, constructs a psychologic system which has not proved wholly acceptable to the more rigid Freudians. Rank's work is brilliant in conception and gives a welcome unity to parts until now disconnected. Time will be needed to determine the proper place of this contribution in the development of psychoanalysis.

In comparison with older schools of psychology, psychoanalysis contains new material and makes radical departures from other points of view. This matter may be summarized as follows:

a. Psychoanalysis deals chiefly with the "unconscious" mental life, maintaining that the more important mental activity goes on outside the subject's awareness.

b. It establishes *repression* as a central psychologic mechanism, meaning by repression a purposeful omission or elimination of mental material from consciousness. In normal states this mechanism disposes of what is unnecessary and inconvenient for consciousness. In abnormal states it takes care

of what is intolerable and insolvable by consciousness. The difference between healthy and pathologic repression is chiefly one of degree. Healthy repression is a mechanism for the efficient management of childish and asocial qualities that are common to all. Pathologic repression comes into play under special need, and is used to evade tendencies that are so potent and in such crude contrast to anything acceptable by consciousness that they cannot be disposed of by more constructive means. In both cases the material repressed remains in the unconscious. In the former it is integrated into the structure of the mental organization and is compatible with health. In the latter it remains unassimilated, is a source of inner mental disharmony, and is often the basis of neurosis and other maladjustment.

c. Psychoanalysis recognizes unconscious mental conflict as a source of psychic difficulty. Conscious mental conflict is apparent to all. The conception that such conflict may go on completely outside the conscious grasp of the individual is distinctive to psychoanalysis.

d. There is a new emphasis on infantile and child psychology, again with a stressing of the unconscious features. Appropriate psychologic development at this early period is felt to establish patterns of reaction that insure satisfactory adult adjustments. On the other hand, failure in the solution of some basic developmental problems may result in their being carried over to adulthood, as a sort of unfinished business of the past, which complicates all later mental reactions.

In so far as psychoanalytic psychology is a system, it is a psychology of the instincts, or rather the instinctive basis of mental processes, and thereby accepts a biological foundation. Freud postulates two groups of instincts: the sexual, or procreative, and the ego, or self-preservative. In a sense, these two groups are set in opposition, the sexual instincts striving for independent outlet, the ego instincts molding them to appropriate and useful social expression. Freud's earlier work dealt mainly with the first group. This is made up of a wide variety of factors, but all are reducible, according to him, to a common denominator, which, in the wider sense, is sexual in nature. Psychoanalysis has an energy concept of psychology analogous in a way to the energy concept of physics, and, to

continue the parallel, most of the energy manifestations of the psyche are derivatives from one common source, the procreative or sexual energy, designated the *libido*. In accordance with this concept, the so-called libido theory of Freud was developed as a central theme around which the elaborate structure of psychoanalysis has been built up.

Stripped to its bare bones and given in merest outline, Freudian psychology, normal and abnormal, is explained by the libido development and its vicissitudes. Undifferentiated at birth, the libido goes through an orderly course of evolution from the simple organization of the child to the complex organization of the adult. This libido development manifests itself on two planes—development in relation to *aim* and development in relation to *object*. Aim development is concerned with the physical organism itself, and with the libidinal investment of various bodily systems. At birth the libido is diffusely and somewhat homogeneously attached to all body orifices, special senses, skin, and musculature, which together are designated as infantile erogenous zones. From then until the age of four years, or thereabouts, a reorganization takes place in the nature of differentiation and specialization, until the libido investment is drained away from other organs and concentrated chiefly in the genitals. There is then later established, so far as aim is concerned, a harmonious organic whole, manifested in the so-called primacy of the genital zone, with subordinate coördination of the other erogenous zones. The aim organization of the libido is illustrated objectively in the adult by the act of coitus. In this consummation of the love relation, the genital goal is supported by other preliminary physical contacts—kissing, caressing, looking, and so on.

For various reasons, orderly development of the libido in relation to aim does not always occur. *Fixation* may take place at various levels of development, and a too intense libido investment may remain permanently at some of the preliminary stages. There is then discord rather than order among the libido elements, and a unified aim organization is prevented, leaving the individual variously handicapped in the working out of his love life. In the sexual field proper of adulthood, these over-invested partial impulses may come

to the surface in full flower with imperative demand, and be the basis of sexual perversions. In a less crude and simple way are also explained such sexual abnormalities as impotence and frigidity. On the purely psychic side, where difficulty from similar libido disturbance more commonly shows itself, there may develop neurotic symptoms and other maladjustments. In this connection Freud has referred to the neuroses as the "negative of the perversions".

It must be kept in mind, if one wishes to grasp clearly Freud's thought, that sex as he uses the term means something more and different than is usually understood. The ordinary person thinks of sex in terms of behavior, to be indulged, desired, or abhorred. Freud, in contrast, has in mind more often the psychologic preparedness for behavior and attitude—*i.e.*, the subject's inner state of libido development. In other words, the ordinary person thinks of sexuality as physical phenomena, while Freud deals with it chiefly as mental phenomena. There is reason to believe that a different choice of terminology might have avoided some unnecessary confusion.

The theory of libido development in relation to object is less schematically simple than that with reference to aim. The brief presentation that follows requires an over-simplication that can hardly be conducive to conviction. It is hoped, however, that it may supply a basis for the later discussion of therapy. The mother, as dispenser of food and protection, is the first object of emotional interest on the part of the child, which interest Freud conceives as a libido manifestation. The necessary thwarting and rebuffs in training throw the child back on himself, and for a period the libido is engaged in a self-love called "narcissism". The auto-erotic habits of early childhood, thumb sucking, genital handling, and so on are physical manifestations of this narcissistically directed libido. Next, a homosexual stage is entered, during which the individual loves those "like himself"; and later a heterosexual level is attained, externalized first at puberty, when the central current of love interests turns toward the opposite sex as a preliminary attitude to later mating.

The much discussed *Œdipus*[1] *situation* belongs in the field of object relations. The child enters this phase of his development at about the same time as the primacy of the genital zone is established—*e.g.*, the fourth year. The Œdipus situation has been designated the nuclear complex of the neuroses, and by the same token may be considered the nuclear complex of health. Simply presented, these statements imply that the way the child solves his early libido relationships with the parents determines his fitness or unfitness for meeting later in life other human relationships and the world of reality in general. The Œdipus situation may be conceived as the original triangular love relationship, made up of child and parents, most of the drama, be it emphasized once more, going on in the unconscious of young Œdipus—a subjective triangle rather than an objective one. Here is experienced the earliest apprenticeship in actual emotional adjustments, and the degree of its success or failure marks a good start or a poor one toward all later human relations.

Using the boy for illustration, the little egotist wishes to monopolize his mother for a love object. Immediately he finds himself in a critical dilemma. He must renounce his need for exclusive monopolization of the mother or find himself in competition with the father. If he holds to his first purpose, he must both wrong the father by usurping his rights and hate him as a rival. From these attitudes spring guilt and fear. The normal child solves this intolerable problem by a constructive renunciation which emancipates him from the Œdipus situation and permits him to strive on toward new goals. Others, unable to renounce, are forced to some unsatisfactory and compromise solution, which results in an imperfect orientation of their libidinal make-up, adequate, perhaps, for the remainder of childhood, but insufficient to give them the necessary freedom for adolescent and adult adjustments. More technically speaking, libido fixation may occur at any stage of object relation in a manner akin to those in relation to libido aim, and form in a similar way the basis for later perversion or neurosis.

To those unfamiliar with the data of psychoanalytic find-

[1] So called from the Greek legend of King Œdipus, who, moved by forces of which he had no knowledge or control, slew his father and married his mother.

ings, the theory of libido development, with its implication of infantile sexuality, sounds like the flimsiest vagaries of fancy. It still further strains credulity to find that all these extraordinary proceedings of the libido go on outside of consciousness, and that little has been directly observed in the behavior of children to substantiate these hypotheses, which are formulated, instead, as a reconstruction of the past from the study of the mental life of neurotic adults. However, theorizing is no new procedure in the progress of knowledge, and demands no justification in itself. Psychoanalytic study of the human mind brings forth seemingly unequivocal data completely overlooked by former methods of investigation. Psychoanalytic theories have been established in order to give working concepts for the interpretation and understanding of these findings. There is no reason to believe that these theories are complete or final. In fact, except in a few fundamentals there has been continuous change and development since the beginning. Substitute theories that will explain facts as well, and be as useful in understanding and therapy, are always in order. The nature of the subject matter makes difficult or impossible the experimental confirmation demanded by strict scientific method. It may well be that many of the problems of mental life must always remain in the realm of philosophy rather than of science.

Psychoanalysis as a system of psychology has an important bearing on many of the biological and social sciences. However, the main medical interest is, of course, in the application of its theory and practice to the problem of the neuroses. Nervous illness is explained by Freud in accordance with the libido theory. For a person to adjust to life harmoniously, and live at peace with himself and the world, an appropriate socialization of his instincts is essential. In psychoanalytic terminology, psychological health requires that the ego shall be in control of the libido. "A person only falls ill of a neurosis when the ego loses its capacity to deal in some way with the libido."[1]

It is to be noted that Freud's neglect of the organic side in

[1] *Introductory Lectures on Psychoanalysis.* By Sigmund Freud, M.D. Authorized translation by Joan Riviere. London: George Allen and Unwin, 1922. p. 323.

psychology and psychopathology is not due to repudiation of its theoretical existence. He states: "We must recollect that all our provisional ideas in psychology will some day be based on an organic substratum. This makes it probable that special substance and special chemical processes control the operation of sexuality and provide for the continuation of the individual life in that of the species. We take this probability into account when we substitute special forces in the mind for special chemical substances."[1] At the present stage of scientific knowledge, however, Freud agrees with other members of the so-called "functional" school that to bring in a hypothetical organic physiology and pathology to explain mental processes complicates theory and retards progress, with little return in the way of compensatory gain.

Various schools of psychoanalytic thought have developed, notably those of Jung and Adler, which diverge markedly in some respects from the distinctly Freudian principles. But the roots of all these systems have a common origin in the work of Freud. Whatever may be the special merits of these particular contributions, it stands to reason that, as Stekel happily puts the matter in metaphor, "A pigmy on the shoulders of a giant may be able to see farther than the giant himself." In the last few years there has been evidenced new interest in "ego psychology", so called in distinction to the libido psychology chiefly emphasized by Freud. Rank and Alexander are the leading exponents of this line of thought at least so far as the problem of neurosis is concerned, although here, as elsewhere, Freud has blazed the way. Briefly, ego psychology emphasizes that part of the human personality which represses, in distinction to that which is repressed. In contrast to the libidinal instinctive trends that still remain the dynamic source of mental activity, the social and ethical forces of inhibition, modification, and control are given more consideration. In some of this new doctrine, sexuality in the sense of the libido theory assumes a new relative position. It is looked upon rather as manifestation than as cause, perhaps the most important and central phase of human psychology,

[1] *Collected Papers*, by Sigmund Freud, M.D. Authorized translation by Joan Riviere and Alex and James Strachey. New York: International Psycho-Analytic Press, 1924–25, Vol. 4, p. 36.

and certainly a standard of measurement for psychological health or illness. In the light of these views, Freud's axiom that "with a normal sex life there can be no neurosis" might be changed to *a normal sex life is an index that marks the absence of a neurosis.*

From the standpoint of principles and technique of therapy, the fundamental principle of procedure in psychoanalysis is to take the patient back to the source of his unsolved mental conflicts, activate the factors once again, and aid in a new and better solution. This backward journey is carried out simultaneously in two ways: first, intellectually, by means of a reconstruction of the past through memory; and second, emotionally, by the actual experience of the analysis itself. The first means referred to is more important so far as the research side of mental study is concerned, but the second has a much greater significance in therapy.

The intellectual reconstruction of the past includes a searching autobiographical review of the whole life history. Often no material not already available to the patient is brought to light. In other cases, notably the hysterical group, the horizon of recollection is markedly extended, and many wholly forgotten incidents and attitudes appear, reaching back to very early childhood. In either case, the whole matter of life experiences and influences is newly evaluated. In addition to the conscious autobiographical study, it appears possible, by inference and indirection, to get at much of the unconscious mental past which is wholly inaccessible to ordinary means of investigation. This material includes in particular the Œdipus situation and the various patterns of reaction laid down in childhood by the family relationships in general, anomalies of which form the basis of the psychoneuroses.

The emotional experience of the analysis, the second means for reaching the source of old and unsolved conflicts, will be treated under the topic of *transference.*

The technique of psychoanalytic therapy is characterized by five features: (1) the physician maintains a passive rôle; (2) the emotional relation between patient and physician called *transference* is put to systematic and special use; (3) a type of thinking called *free association* is taught the subject and used as the main method by which he reveals the deeper

content of his mind; (4) a distinctive and important use is made of dreams; (5) little attention is paid to the special symptoms which bring the patient for treatment. In contrast, consideration is given to the patient's personality as a whole, and study is directed toward the basic mental organization where lie the real difficulties of which the symptoms are merely the surface expression.

Each of these five features can well be considered in turn. It should be kept in mind that in both outline and discussion, statements are over-simplified for clearness and need to be interpreted somewhat relatively.

1. *Passive rôle.*—The part played by the analyst is quite in contrast to that of the guide, philosopher, and friend of traditional psychotherapy. He in no way intrudes into the external life and circumstances of the subject. He gives no advice and neither criticizes nor condones, praises nor blames. The analyst's personal affairs, his tastes, views, and philosophy of life are kept strictly in the background. His work is limited solely to assisting the patient in an interpretation of his own thoughts and feelings which arise during the course of the analytical hour. The physical arrangements in the office support the passive rôle of the analyst. The patient usually lies on a couch, the analyst being seated behind and out of sight. Social relations are kept at a minimum. There is no casual conversation on matters outside the analysis. At the end of a long course of treatment with all its intimacy, a subject often knows less of the personal life of the physician than he might of a new acquaintance after a brief chat. The whole procedure bears little of the nature of a discussion. It is much more a monologue by the subject, who talks of whatever comes to mind; in other words, the subject thinks out loud. The analyst may offer interpretations from time to time, or he may remain silent for the whole hour. Periods of complete silence may intervene, when the patient has no articulate thoughts, or is reluctant to talk. The analyst is unconcerned and can wait. The subject does the work. He carries out a personality study of himself. It is impossible for him to do this alone, and the analyst is there to assist. There is little of the teacher-student relation. Rather, the situation consists of two people studying a single problem—the mind of one of

them—and they are interested only in one thing, the truth of that mind which lies behind the ordinary disguise of everyday life.

2. *Transference.*—In all successful psychotherapy, as, in fact, in most medical treatment, a very special emotional relationship exists between physician and patient, which is known as *rapport.* This rapport is by no means confined to medicine, but exists in all close relations, such as may occur between teacher and pupil, leader and follower. Without it, none of these relationships are deeply significant. When rapport is present in psychotherapy, immense power is given to the physician—sufficiently so that patients are helped or cured quite independent of special method. From the beginning of the healing art, this power has been used to relieve symptoms, to inspire courage, to support renunciations, and to aid in bearing burdens. Much of the time, effects have been gained without the physician's being aware of the power he was wielding. The blindness to the meaning of rapport on the part of the medical profession has been nothing short of extraordinary. The force that it represents has been better grasped by the quack healer, who knows that by it he can influence people quite regardless of the worth of his professed agency of cure. Certain medical men have seen fit to disparage the rapport feature in therapy as unscientific and savoring of chicanery; others appear to fear it as dangerous; and still others exalt some special method of treatment, quite oblivious to the existence of the rapport element that gives it life. If it were necessary to choose between method and rapport in psychotherapy, there is little question but that the latter would be the more useful agency.

If psychoanalysis had done nothing more in a practical way than to make its contribution to the subject of rapport, designated by Freud *transference,* it would have well justified itself. The attempt has been made by psychoanalysis to study and standardize these important and powerful phenomena of transference, to harness them, so to speak, and make them available in a systematic and controlled way for psychotherapy. To be sure, no one knows what rapport consists of. No wonder the scientific world is shy! There is magic and mystery in it. Its absence leaves words of logic and wisdom fruitless and sterile.

Its presence may make these same words potent for influence. Personality with a capital P is the word popularly applied to the special mysterious something in the physician that makes possible the easy establishment of rapport. Accompanying this term is often the implication of the dynamic, authoritative, and dominant person who is always the leader in any field of activity. In the transference situation of analysis, it has been shown that no special type of personality is essential to gain rapport. The quiet, less assertive individual seems as well able to play the part as his more robust-minded brother. Apparently what the neurotic person longs for is understanding, and when he finds it in a professional relationship, a satisfactory rapport can be easily enough established, either with or without the sense of leaning on a master mind.

In much of the usual psychotherapy, a permanent relation tends to be established. The patient orients his life around the physician, and looks to him for inspiration and guidance. The rapport connection remains a permanent one, even if direct contact is rare. Janet refers to the physician's part in this relation as "directorship". We all know people who are directed in such a way by a physician or some one in another capacity. This is often a necessary and perfectly good arrangement, but it is not the method of psychoanalysis. In psychoanalysis the power of rapport is employed in a different and special way. It is not used for guiding the patient or immediately to affect his symptoms. It is directed toward enabling him to carry out a study of his own mental life.

The first step in this process is to bring to the surface trains of thought which ordinarily are automatically repressed, and which bear strong and painful affect. Special timidities, fears, disloyalties, aversions, and so on, jealously guarded by the neurotic even from himself in real life, are given immense relief by this ventilation. The patient, so sensitive toward criticism or disapproval, is comforted by finding in the physician one who accepts without appraisal and shows equal interest and tolerance for the strong features and the weak, the good and the bad. The patient learns that, after all, he may not be so different from other people. His inferiority is lightened; he feels hope, and his attitude toward the analysis is that at last he has found what he has been looking for—some one to

understand him. This long-sought-for goal he thoroughly believes to consist in recovery from his illness. As a matter of fact, it is much more a justification without conflict of his present level of adjustment for which he strives, and the knotty problem in therapy is to substitute for this latter palliative procedure a more constructive reorganization of function. In any case, this preliminary stage binds the subject still more firmly in the analytic situation.

As a second step, he begins to experience rather than remember his past—*i.e.*, certain parts of the past become reanimated and he lives them over again. With this what Freud chooses to call a "transference neurosis" develops, which means that for the time being the subject shifts some of his conflicts and difficulties from the problems of the past and of his usual world to the analytic relationship. The matter of the transference situation in analysis is difficult to describe, but not so difficult to experience either as subject or as analyst. Freud speaks of the "general tendency of human beings to transfer", meaning that all men have a need for understanding, sympathy, support, and so on, which is never wholly fulfilled in ordinary human relationships, with the result that there is a constant reaching out for more complete satisfaction. This universal need and longing furnishes, no doubt, a foundation for much of the religious tendency of mankind. Whatever the case may be with normal individuals, it is plain that the neurotic tends strongly to transfer. He brings into all his contacts with people childish and undeveloped emotional needs and strivings carried over from the past, which are doomed to be thwarted and violated in a normal adult world. Even if these needs, egocentric as they are, were in themselves capable of satisfaction, the fact that he must deal with other people, each with his or her own special demands and perhaps no better prepared than the patient himself, spells continually disappointment. Furthermore, these arrested emotional trends of the neurotic are by their very nature conflicting and incompatible. There is lacking the unity and integration of the normal personality. What satisfies one part, violates another and the individual is forced to a continual state of repression, inhibition, control, and compromise. This conflict of demand may be illustrated by the not unfamiliar

type of neurotic who longs to find in all his contacts with those in authority the image of the protective father upon whom he can lean. Actually, in such relationships his own independence and manliness rise in protest at the subjugation that he creates for himself, and on the surface his final attitude may be rather one of defiance than of dependence. The neurotic is for the most part unaware of these conflicting inner trends. He only knows that he feels isolated in a world of people and suffers from symptoms and dissatisfaction.

The analytical situation developing during the analysis is to a certain extent artificially constructed to make it possible to bring up into the open these undeveloped, inadequate, and conflicting needs in a way that cannot be accomplished elsewhere. The analysis is a one-sided relationship, in marked contrast to those of the real world of daily living, or, for that matter, to the ordinary professional relationship. This one-sidedness permits the subject to set aside the usual social veneer of his mental life, and to come, for the time being, nearer to the real self underlying the every-day official personality. Freed from the necessity for artifice and control, he repeats the past in phantasies and attitudes in the analysis. Instead of recalling old patterns of reaction, he relives them during the analytic sessions. From this experience, a patient, suitably selected, is enabled to see himself as he really is—to realize the inadequacy of his emotional preparation for adult living and to grasp the impossibility of satisfying some of his demands. By means of this combination of experiencing and understanding, he is able to revise in terms of adulthood some of his infantile strivings and to dismiss in the light of adult knowledge his crushing internal verdicts on crimes of infantile imagination. The analysis gives him the opportunity for something of a laboratory sampling of his whole life plan, expressed in words instead of action, and quite free and apart from the need of maintaining responsibility and control, which, in ordinary living, he dare not relax. The analyst acts in this laboratory setting less as an individual than as a composit phantom figure of the childhood past, in its family setting, and toward this figure are reactivated all the main relationships that have played a formative part in the patient's life.

Not all of this is seen as clearly as outlined above, either by subject or analyst. Part of it appears distinctly in conscious awareness, and in actual emotional reactions directed toward the analyst. Much of it goes on beneath the surface and is grasped only by indirection through dreams and so on. In other words, the transference relation exists both consciously and unconsciously, and like other relations of real life, at times the two attitudes are in accord and at time diametrically opposed. The ambivalent and ununified emotional life of the neurotic is revealed in transference with its positive and negative features. On the one side are need, dependence, and a reaching out; on the other, are withdrawal, hostility, and resentment. One side or the other only may be seen on the surface, but the opposite is usually active on deeper levels. Over and over in this analytic experience patients relive and thereby reveal important parent-child or other early relationships, left unsolved, buried in the unconscious, and carried over to adulthood, to condition all later reactions toward people. Thus is accomplished by a controlled experiment in actually living what would defy an understanding by objective study and intellectual approach.

Part of the analyst's training is to be emotionally untouched himself by this transference relation. Otherwise it becomes a human problem for the patient, like any other, and the deeper revelation sought for is defeated. The analyst must be as immune to criticism, hostility, and even insult, on the one hand, as to deification or adoration on the other. In analysis, all these attitudes are reflections of deeper complex motives and sources which the analyst patiently and steadfastly seeks to uncover. He recognizes full well that it is less as an individual than as a symbol and substitute that he is functioning. He is permitting himself, as it were, to be used as a foil, in order that the patient may thereby get into deeper touch with his own mental life. The analyst's passivity and refusal to enter into any reality relationships, even to the extent of a friendly argument, enable the patient to arrive at a convincing emotional realization of the persistent infantile tendencies responsible for his neurosis.

It is not so difficult to establish a transference. If the patient continues the treatment, he does that of his own

accord. To do away with the transference is a more difficult, but equally important procedure. The analysis is not complete until the patient has freed himself from the transference situation—that is, until he has given up the analyst as an object of very special significance in his own emotional life. In a sense, it may be said that the goal of the analysis is to teach the patient to live with the analyst on an adult rather than on an infantile plane. This accomplished, he can go back to the ordinary world of men better prepared to carry on the same level of relationship.

3. *Free association.*—Free association is a method of thinking in marked distinction to that ordinarily carried on, even in the most idle phantasy or daydreaming. In ordinary thinking there is a constant automatic tendency to eliminate the unpleasant or difficult. This is not always possible, so that often enough painful lines of thought take possession of the mind. Frequently this reaches obsessional intensity, and a train of futile and unpleasant thinking repeats itself indefinitely. In free association, the subject is encouraged to permit his mind to be passive and undirected, and in this state to put into words as well as he can the thoughts, pictures, and feelings that drift through. It is emphasized that everything belongs in the analysis, no matter how disconnected, irrelevant, trivial, personal, or unpleasant. This procedure, of course, requires the complete coöperation of the patient, and the ability to acquire competence differs markedly. Most subjects can gain a sufficient degree of proficiency to make the method a practical one. In the familiar word-association tests, Jung has attempted to standardize the free-association method. This special application has found a useful place in experimental psychology, although at present less often employed in ordinary clinical procedure.

Criticism has been offered that free association in analysis is not free, but is determined by special conditions, including the personality of the analyst. This criticism is no doubt sound, but free or not, the method described enables the individual to go deep into his own mind. The term "free association" remains, if one pleases, as a convenient misnomer to designate a special process. It is found that wherever the starting point may be, free association progresses finally

toward the fundamental problems of the maladjusted person, which, as a rule, lie far too deep to be available by any direct approach. The routes of free association are circuitous, with wide detours and frequent retracement of steps, but always, if persisted in, they lead in the direction of the problems sought.

Without some experience in free association, one is unaware of the lack of freedom in usual thinking, to say nothing of talking. As an illustration may be used the attitude of an individual toward a friend, even if the occasion for such an analysis is difficult to be imagined. The conscious attitude is one of interest, affection, and loyalty, but this is the final integration of many elements that go to make up a whole. Some of these elements are probably quite at variance with the final common path of friendship. Jealousies, malice, distrust, and resentment may have a place, though not important enough to offset the stronger and more desirable feelings. Ordinary thinking tries to dismiss and eliminate these discordant notes. Free association tends to bring them up to the surface.

A natural question arises as to why there should be any attempt to unearth underlying partial and discarded components of mental attitudes. The answer is that no reason exists save one—viz: that such disharmonious trends are the cause of neurotic or other difficulty, and in such case there is a good chance that they can be handled better if made conscious and brought into the open than if left buried alive in the depths of the mind. That the inevitable goal of free-associative thinking should be some phase of the most important life problems seems clear enough. Certainly it is true with the more obvious problems of external life. If a man had recently suffered financial disaster and were asked to be quite passive mentally and to think of the North Pole, or some other neutral matter, it would not be long in his associations before his misfortunes came to mind. Perhaps it is only a difference in degree from what is seen when the thoughts of a neurotic, wherever they start, drift toward some manifestation of the repressed, unconscious, unsolved psychic aftermath of infantile conflict, which are his real problems of to-day. It proves to be a fact that thoughts in free association, however disconnected and

unimportant they may seem to be, are joined together by threads of connection located in the unconscious mind, which give bias and direction. By this method sooner or later deeper layers of mental functioning are progressively revealed.

4. *The use of dreams.*—The subject of the meaning of dreams and their use in psychoanalytic therapy can be little more than summarized in this paper. According to Freudian theory, dreams are a more direct expression of the unconscious mental life than are any other psychic phenomena. This expression is in disguised and symbolic form, both for the purpose of condensing material and of protecting the dreamer from conscious recognition of certain repressed mental processes set free in the dream. Based on this relationship of dreams and the unconscious, they prove to offer a more direct access to the deeper levels than do other manifestations of a subject's mental life. They may be used in two ways, either as a starting point for the free-associative method of thought, or by direct interpretation of the dream, to reveal the unconscious mental states behind it. Interpretation of dreams is a somewhat risky procedure, in that it is hard to draw a fast line between sound fact and specious fancy. It is no doubt true that there are many levels for meanings of dreams, and that they can best be interpreted by taking into account their relation to the whole problem that is being studied. Certain types of dreams and simple standard symbolizations are possibly exceptions to this rule, and the significance of such dreams is fairly generally accepted, except where the Freudian dream theory is repudiated altogether. Free association in relation to dream elements appears to give the method the advantage of a short cut in analytical procedure. As a rule, neurotic patients have dreams, but occasionally there is an exception. In such event, the analysis has to go on without this advantageous material. This usually is something of a handicap, but in no way prohibits a successful analysis. At the present day the use of dreams for diagnostic and therapeutic purposes is by no means confined to psychoanalysis, and is emphasized in some degree by modern psychiatry in general.

5. *Management of symptoms.*—Naturally, the patient's mind is at first full of his own symptoms and problems.

Analysis, to a considerable extent, must ignore them. It has as its object something more and different than direct relief of symptoms, good as such treatment may be in certain cases. It is assumed, of course, that analysts employ common sense as well as special method, and there may be exceptions to the rule. It is taken for granted, also, that before the analysis was undertaken, organic basis for physical symptoms was eliminated by competent medical study, and that there is no crisis in the external circumstances of the patient's life which cannot wait for settlement until the analysis is over.

Usually the lack of comment on the part of the analyst leads the patient to drift away from the subject of symptoms. It seems that for the most part it takes two to keep a topic going. If nothing else comes to the patient's mind, his annoyance, perplexity, or grievance at the analyst's attitude is made manifest and a new line of thought is started. Occasionally symptoms are so intrusive and monopolize the mind so completely that they cannot be ignored. If these are physical symptoms, the patient is referred to a medical colleague. If the need is for advice in matters of daily life, some other outsider can best be turned to. It is well that both have some sympathetic point of view toward the analysis. With the responsibility of these matters shifted to others, the analysis can then proceed. Its one interest in current conflict and problem are as they offer material for analysis.

The following example will illustrate both the matter of free association and the management of distressing symptoms that obstruct analysis. A young man had been under analysis for a severe anxiety neurosis. Among his symptoms was a fear that pieces of food or glass would become lodged in his throat. This phobia led to all sorts of food prohibitions and the necessity for repeated daily reassurance from family and physicians. On principle, the analyst declined to give special attention to these symptoms, leaving the patient quite free to turn to his former sources of support. In spite of this arrangement, these symptoms so filled his mind that no other material was available. Hour after hour he maneuvered to get the analyst to take the rôle of authority and to reassure him. His distress was no less acute on account of complete insight into the lack of basis for his fear and a realization that the analysis

was being obstructed. One interview was discontinued, and at the analyst's suggestion the patient went rather shamefacedly to consult a laryngologist. During this examination he was able to see the humor of having his throat looked into for something he knew quite well was not there. At the next hour of analysis, the patient discouragedly announced, after a period of silence, that all he could think of was that a peanut was stuck in his throat. He was asked to let his mind be passive and to continue to think of his throat. Immediately a scene from his childhood was recalled. He had entered his parents' bedroom when both of them were scantily clad; his father reproved him sharply, and the boy felt anger and resentment. This long-forgotten scene coming to mind in such association caused the young man astonishment. The throat symptom was lost sight of for the time, and he talked of other events of his boyhood. The relation between the throat phobia and the family emotional drama of childhood illustrated by this bedroom scene later became clear enough—during this interview some thread of connection joined the two topics in free association. To the objection that this connection had been suggested by the analyst, it can only be stated that with as fair consideration as could be given, such did not appear to be the case.

In dealing with a nervous illness, one is faced with the strange and paradoxical fact that the patient clings to his neurosis as though he did not wish to get well. He suffers, often enough he complains bitterly, and he is unhappy. He sacrifices time and money for treatment. He longs for health and freedom, and protests his willingness to make every effort, yet unmistakably he defends himself adroitly against therapeutic influence, and holds to his symptoms as if they were something precious. This instinctive opposition to medical aid is called *resistance* by psychoanalysts. The novice in psychotherapy is apt to be much annoyed by the phenomenon of resistance. The patient does not want to be helped? Very well—tell him in no uncertain terms what you think of him, and give up the case.

More careful consideration of the nature of nervous disorders makes less puzzling the resistance that is set up against therapeutic attempts. A neurotic illness is no accident. It

marks the failure to stand up before the demands of life as the direct consequence of inadequate psychological preparedness. The normal man has worked out the best plan of mental organization that he can in order to avoid pain and achieve satisfaction. For the most part he knows and cares little about this inner mental life. The whole thing operates with as little relation to consciousness as does the digestion of a healthy boy. But somewhere the normal man has a useful scheme of values, emotional needs capable of satisfaction in a grown-up world, and some sort of philosophy of life that keeps him in tune with the universe.

After all, in general policy, the neurotic has done no differently from other men. He, too, has constructed his scheme of life to avoid pain and achieve satisfaction. The fact that this scheme has broken down makes it no less his own, the best under all the circumstances that he could do for himself, and it seems to him the lesser of two evils when compared with any alternative. Consciously he recognizes his difficulties and is ready to change. Unconsciously, he holds with might and main to the status quo. To be asked to let down the repressions that have been built up so painstakingly to hold an undeveloped emotional life in control strikes panic to his soul. It seems to him far safer to hold to the evils that he has than to fly to those he knows not of.

Something like what is described above is, in a general way, the main theme in resistance. Many other secondary factors enter in. For example, there is the so-called "gain from illness", where symptoms appear to gratify impulse needs substitutively, even though at the same time they cause distress in other ways. Also, the transference situation itself produces a special and stubborn resistance in the nature of an attempt to find in this new relationship a comfortable and protected existence, which is threatened by recovery. At times the resistance is so unyielding that there is little chance of breaking through. This is true in paranoid states and the major hypochondriases and, in lesser degree, applies to some obsessional neuroses. In other cases, the gain from illness is too practical and obvious to be lightly set aside. This is evident in that type of neurotic who, by his symptoms, has acquired special privilege and freedom from obligation. Appropriately chosen

cases for analysis must be those less rigidly organized than the paranoid and with more robust qualities of personality than the one who is a neurotic for special privilege. With these the central point of the analytic art is to break down resistances. Resistances rather than " complexes " are what the analysis is ever seeking to discover. In just so far as these can be removed is it possible to get at and modify the underlying psychic states from which spring the roots of the neurosis.

Resistance, therefore, is always present in analysis. If none is evident, then beware! It is operating under some new and unrecognized disguise. Neurotics, like other people, are very much alike, and there are many standard manifestations of resistance. Some of the more familiar are exaggerated criticism and skepticism of the analysis based on something other than the merits or demerits of the case. Plain boredom at the tediousness of the process is not uncommon. As already noted, physical symptoms may intrude themselves so forcefully into the patient's mind that there is no room for other material. Depression or anxiety may reach such intensity that no analysis is possible till some relief is forthcoming. Often the patient ingeniously attempts to intellectualize the analysis, to lift it to the level of objective discussion; or he tries to turn the tables and analyze the analyst. Again, he may suddenly cease dreaming, or on the other hand bring such a confusion of dreams that the very mass of them defies analytic consideration. One adroit bit of super-resistance is rapid recovery. The patient feels quite well again. He is interested and appreciative of the analysis, he will recommend it to his friends—but there is no need of continuing in his own case. Selective amnesias of all sorts occur: material or interpretations of special significance are repeatedly forgotten in a way difficult to credit without actual experience. The use of wit to avoid direct issues is not unfamiliar. In the matter of free association, resistance may show itself by complete inability on the one hand or, on the other, by endless and footless rambling in self-indulgent phantasy.

Resistance brings analytic procedure to repeated states of deadlock. Occasionally there is no passing by, and the analysis must be discontinued. More often, with a suitable patient, the analyst is able to point out resistance, and if this

explanation is in any way accepted, the deadlock relaxes and the analysis proceeds, the patient falling back, as it were, to still other positions of resistance, where the same process of overcoming must be repeated. At times the analyst, from his experience and in his detached position, sees these points of resistance clearly, at others he, like the patient, is groping forward for a period in the dark.

During the treatment hours, the patient, so far as is possible, gives up self-direction of thought, lets his mind drift, and by means of speech empties its content, so to speak, into the analysis. The analyst listens to this material, subjects it to the test of his own trained mind, objectively related to the problem, and attempts to determine what motives and elements lie behind. The patient complains that the analyst ignores the obvious, is suspicious of everything, and seeks deep and hidden meanings. The charge is true; in the neurotic, things are not what they seem, and it is the business of analysis to question everything. At times meanings are clear; very often they are obscure. Positive interpretation, when things are plain, and a questioning attitude when they are obscure, seem to make it possible for the patient to shed layer after layer of disguise and come nearer and nearer to the real problems of his mental life. Even questioning and hypothesis proved later to be quite off the track apparently do no harm, and in a properly conducted analysis the patient himself sifts the wheat from the chaff.

The detail of analytic technique is changing, and will change much more. Among other things, the single fact that most educated people are informed on psychoanalytic theory has made for revision of method. Formerly a memory reconstruction of life history and the revealing of formative mental mechanisms took first place. In this the causal features of the pathology were given first consideration. Now the emphasis is laid more on the analytic situation compounded of transference and resistance—*i.e.,* the emotional experience rather than the intellectual one. The analysis furnishes, as it were, a small edition of the emotional life history of the subject, the inadequacies of which he learns through actual repetition. It is a truism that one cannot live his life a second time. In some respects, an analytic experience seems an ex-

ception to this rule. Certain poorly developed features of the emotional life are lived through a second time, and thereby the subject is given another opportunity to do better with them.

The therapeutic analysis takes much time—from a few months to a year of daily interviews is common. It is not difficult to see that the time element is important. The method is educational rather than inspirational or conversional, and education takes time. For practical reasons, however, everything that short-cuts analytical procedure without sacrifice of accomplishment must be welcomed, and steps have been made in that direction.

Diagnostic analysis is often relatively simple. In many cases, after a few interviews the analyst grasps some of the more general features of psychopathology involved. This is nothing strange. After all, the main fundamental themes of human life are few, and the general lines of difficulty are much the same. But what the physician knows or thinks helps the patient very little. Somewhat as in the case of music or the fine arts in general, so in the art of mental adjustments, what a second person knows is of value only in helping the other to gain by his own experience. The matter, however simple in theoretical formulation, cannot be imparted by word of mouth.

To sum up the significance of psychoanalytic treatment, it is the belief of its advocates that the patient is given a unique and carefully worked out opportunity to change from emotional dependence to emotional independence, and to grow from his state of childishness to one nearer adulthood. His personality is organized on an imperfect, but rigidly crystallized basis. Analysis is an attempt to reach deep down, to loosen or liquefy this structure, and to make possible thereby a reorganization on a new and better level. Massive experience in real life occasionally accomplishes this same thing. A great love, some deep religious awakening, a sudden demand for duty and sacrifice, or a self-obliterating social movement, such as a "holy" war, may, as it were, lift an individual bodily from his own difficulties and leave him a changed man.

Obviously, the mass of neurotic and maladjusted people are not going to be cured by such accident of circumstance.

Analysis is an attempt to accomplish by systematic, standardized, measurable procedure what cannot be well left to the uncertain fate of spontaneous growth.

Questions that naturally arise concerning psychoanalysis are: For what type of patients is it suitable, and what is its relation to other methods of psychotherapy? Psychoanalytic treatment of the technical nature described applies only to a selected group of cases which is limited in various ways. A considerable degree of intelligence is essential. On the whole, after the first half of life, the method is not advisable. The circumstances of the patient's life must be such as to give him opportunity to gain satisfaction in normal living. Such things as hopeless poverty, failure in ambition, severe bereavement, or an unhappy, but binding marriage bond may be insurmountable obstacles. Such people will profit more from methods of consolation than of reconstruction. Most psychoanalytic work has been with neurotics, and little is known as yet of its influence on psychotic patients. Psychoneurotics, to be helped by psychoanalysis, must have considerable fundamental stamina of personality. Nothing is added to a man by this method, and he is given no crutches to lean on. He can profit only as he has promise of better things within himself. The obsessional neurotics, conversion hysterias, certain sexual abnormalities, and the common anxiety states offer the most favorable material for treatment by analysis.

Psychoanalysis has been called the major surgery of psychotherapy. The comparison does well enough. Like major surgery, analysis does not help everything, nor is it usually the first method to be thought of in case of trouble. Most nervous difficulties can be helped by more simple methods. Perhaps one may say that analysis, like surgery, should be reserved for those problems which less radical procedure does not reach. The time and money involved make psychoanalysis a therapeutic luxury. As is the case with private sanitaria, trips around the world, and so on, it must necessarily be beyond the means of the majority of people. Certainly the vast numbers of psychoneurotics in both clinics and private practice will have to get along without it. Other psychotherapeutic methods—suggestive, persuasion, common-sense teaching, directorship, and so on—will remain the chief resources

in psychotherapy. It is true, however, that psychoanalytic doctrine has influenced all methods of modern psychotherapy. Perhaps the therapy of choice for the future will be some eclectic procedure borrowing from all sources and enriched in depth by the analytic school. In prophylactic measures through general education, psychoanalysis can certainly add much to the self-understanding of the individual, which the complexity of the modern world makes desirable.

In conclusion, a word of consolation and encouragement may not be amiss for the "tough minded" and scientifically conditioned individuals, provided any such have read thus far. The physician trained in objective scientific method often finds much of psychoanalysis highly perplexing and irritating. It is his custom to require clear-cut observation as a basis for conclusion, to deal cautiously with hypothesis, and to remain uneasy in mind until it is checked by experiment. In psychoanalysis he finds its hypotheses verified chiefly by its own findings, and sees much that is unverifiable. Such elusive doctrine as the matter of transference leaves him cold with disgust or hot with annoyance. Men of this mind need not concern themselves unduly. There is an easy and dignified way out of all the trouble. One may sweepingly deny that there is any such thing as nervous or mental difficulty which is not the effect of some physical pathology toward which a rational therapy must be directed. As an alternative, it may be maintained that nervous or mental symptoms shall only be dealt with on the descriptive level, and that there is no possibility of getting behind them for motive or meaning. The disinterested and skeptical will find themselves in distinguished company in either of these positions. This company includes neurologists and psychiatrists as well as those more remote in their contact with the subject, and there will be no need for defense or apology in these attitudes. However, the trend of modern thought favors psychogenesis in nervous disorders, and the organist finds himself more and more in the reactionary group. It may well be that another generation will swing back again to a different point of view. Philosophically, at any rate, there must be a unity between body and mind. But for all practical purposes there is a division of the affairs of man into physical and mental, and this whether he be sick

or well. After a century of research, little has been gained from a study of the physical basis for disorders of mental functioning present in the neuroses. The approach to the subject on the theory of psychogenesis, of which psychoanalysis is the most important development, seems to promise far more in the way of understanding and therapy.

THE APPLICATION OF MENTAL-HYGIENE TECHNIQUE IN TEACHING SPEECH*

WAYNE L. MORSE, LL.B.

Chairman of the Beginning Speech Course, University of Minnesota.

AN increasing number of teachers of speech in our colleges and universities are relinquishing the idea that the aim in elementary speech training is to develop in the student the ability to communicate effectively his thoughts and feelings by the use of the auditory and visual symbols of speech. Many of us recognize that the essential educational value to be found in elementary speech training is in the development of behavior habits that will enable the student to adjust himself more satisfactorily to his social environment.

Under the leadership of Dr. Smiley Blanton, who for over a dozen years has been advocating the application of mental-hygiene technique in teaching speech, educators in our profession are beginning to recognize that good speech habits cannot be developed by a student who is emotionally maladjusted to society until that student first understands the causes and effects of his emotional disturbances.

The mental-hygiene approach to speech training strikes a serious blow at the elocutionary and drill methods that prevail in private schools and in many college and university speech departments. Under the elocutionary and drill methods, the student is drilled in the use of platform tricks in order to develop a so-called "platform personality", and is given exercises in vocal gymnastics in order to develop the voice of a "silver-tongued orator". This procedure, however, fails in its aim because it fails to recognize that the problem of good speech is not primarily one of developing physical habits in the use of the speech mechanism, but is basically a problem of developing a state of mental health in the individual who

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desires to influence the behavior of others by the use of speech stimuli.

The elocutionary and drill methods in teaching speech not only fail in their aims, but far too often do serious harm to the mental health of the student, because they often practice what I call emotional butchery. It is a common practice under this procedure to have the student memorize some historic oratorical frenzy, such as Warren's Address or one of Patrick Henry's classics, and speak it with an excess of vocal energy before his classmates. This type of selection is often given to a student who has a marked sense of inferiority. The instructor who adopts this technique seems to think that the assumption of vocal gusto and bombast by a student of this type is an excellent way of building up his confidence in himself.

But in reality the elocutionary procedure may and often does injure the mental health of the student in that it is liable to develop habits of over-compensation to cover the feeling of inadequacy, which the student too well knows has not disappeared because of his assumption of forensic bravado. Then, too, in many instances the elocutionary technique, with its devices of imitation, artificial drills, and arbitrary speech rules, succeeds only in veneering over the undesirable emotional habits which are symptoms of social maladjustment. And under the stress of the future emotional strains which the student will encounter when he faces a speech situation outside of his speech classroom, his old habits of response, which are more deep-seated than the superficial ones with which he has tried to clothe himself, will control his behavior. He will then suffer an emotional experience that will augment his problem of social adjustment.

Those of us who use the mental-hygiene technique in teaching speech believe that the speech class offers one of the best, if not the best, laboratory for the study and analysis of the emotional problems and behavior habits of students that exists in our educational system. In most of our universities, it is the only division of the curriculum that provides the student with the opportunity to analyze his own behavior in relation to his fellows, and to subject his behavior to the

lay criticisms of his fellow students and to the professional criticisms of his teacher. Thus he secures the reactions of society in general through the criticisms of his classmates, and is aided by the professional assistance of one trained in the fundamentals of mental hygiene through the advice of his teacher.

The speech class is such an excellent personality laboratory because, if it is conducted as a socialized discussion opportunity, the student, through his speeches and discussions, exposes his philosophy, his ideas concerning morals, ethics, religion, social relations, and so forth, and thus his speech responses reflect quite vividly his personality make-up. Then, too, there is present in a speech classroom conducted from the mental-hygiene point of view that intimacy of personal relationship between instructor and student which is so essential if our students are going to get the most out of their college training in an understanding of themselves and the factors controlling their own behavior. Unfortunately the average college classroom is characterized by an impersonal instructor-student relationship which prevents the student from deriving from it the greatest benefit for his self-development.

The most important advantage, however, that the speech class provides for the application of mental-hygiene technique lies in the fact that one's speech habits act as a delicate barometer which registers the slightest change in the emotional patterns of the individual; thus through an analysis of his speech habits we are often able to uncover a deep-seated emotional disturbance that has been blocking the normal adjustment of the individual to his social environment. We aim to provide in our classrooms an opportunity for the student to evaluate his personality make-up, to analyze his behavior, his habits of response, his emotional tendencies; and we try to help him substitute new habits of response for old ones which he has learned to recognize as interfering with a normal adjustment on his part. We find that our first task is to get the student to recognize his behavior abnormalities. The very understanding of their causes and effects renders him much better able to condition himself to new habits of

response which eliminate the emotional disturbances aroused by his old habits.

At the University of Minnesota, the mental-hygiene approach to elementary speech training is accepted as the educational criterion of our course in fundamentals of speech. The close relationship between personality make-up and speech habits is emphasized. If one could imagine an individual with all his speech habits eliminated, it is evident that one would be confronted with an organism quite devoid of personality. If we accept the definition that personality is the sum total of one's behavior patterns, then for emphasis we might say, and quite truly, that one's personality is the sum total of one's speech habits.

Hence, when we criticize a student's speech habits, we criticize his personality. When we call a student's attention to a speech mannerism that produces a negative audience reaction, we are pointing out to him that he possesses a personality trait that varies from the hypothetical normal. And thus we direct his attention to an analysis of himself in an endeavor to discover the cause of his behavior, instead of to the assumption of an artificial gesture, for example, which might conceal the personality deficiency, but would do nothing toward eradicating it.

We endeavor to make clear to our students that it is difficult to produce a permanent change in one's personality until one first understands why one reacts as one does, until one understands why one possesses the particular behavior patterns that constitute one's Self. The student is shown the importance of making a thorough analysis of his past experiences because of the fact that it is his past environment, acting upon his inherited structure, that has produced his present personality.

The influence of the past experiences of an individual registers its effect upon his present behavior in the speech situation because that situation emotionally arouses him. Who has ever delivered a speech without experiencing at least some emotional disturbance? If he lives, let him step forth as the only example of an individual in whom the intellectual processes completely dominate the emotional life. The emo-

tional outlets of muscular trembling, perspiring, blushing, general shakiness, random eye movements, inactive salivary glands, and those many other symptoms of emotional disturbance while speaking have been experienced in some degree by all who have endeavored to influence the conduct of others through the medium of speech stimuli.

Before a student can be successfully conditioned to a new habit of response which is in conflict with an old habit of response, he must understand the factors that developed the personality characteristic which he now wishes to extract from his Self. It is at this point that the introduction of mental-hygiene technique in speech training becomes essential. At this point the teacher of speech who has a thorough psychological and psychiatric background and who understands the technique of mental-hygiene and child-guidance clinics can be of inestimable value to a great many students of speech whose behavior difficulties are not of so serious a nature as to require the attention of a professional psychiatrist.

Often such a speech teacher can detect cases of emotional disturbance of a serious nature which otherwise might escape the attention of the professional psychiatrist if the university employs one. I have had several such experiences, and would call attention to the most recent one. In one of my classes I found a student suffering from a deep-seated emotional disturbance. In private conference I found that this disturbance seemed to be produced by conflicts brought on by his orthodox religious training, by undue parental domination, and by antisocial sex behavior on his part. It soon became apparent to me that this student, who had been in the throes of these conflicts for over three years of his college life, needed the attention of a professional psychiatrist, and I so advised him. He was threatening to commit suicide and had purchased a gun for the purpose. Before it was possible to secure the assistance of a professional psychiatrist, this student broke with reality, and is now a dementia-praecox patient in a mental hospital. I am convinced that if he could have been reached early in his college career, as we are reaching so many every year, he probably could have been restored to mental health.

My experience with scores of students who have emotional conflicts of varying degree convinces me that the application of the fundamentals of mental hygiene in the teaching of speech can be of great assistance to the mental-hygiene clinics that fortunately our universities are rapidly introducing. With the establishment of mental-hygiene clinics in the universities, headed by professional psychiatrists, the teachers of speech who possess a sound knowledge of mental-hygiene technique can be important coöperative partners in the work of such clinics. The speech classroom can then be a useful laboratory for the mental-hygiene clinic.

The use of mental hyiene in the teaching of speech, as I see it, involves an understanding by the student of the causes of the various types of emotional and intellectual behavior, an analysis of his own behavior in relation to that knowledge, and its application to the process of conditioning new habits of speech behavior. The important task of the speech teacher is to help the student to make this analysis in accordance with the fundamental principles of mental hyigene and, by means of a process of conditioning and sublimation, to develop those habits of behavior which will improve his social adjustment. It would be desirable to have as a prerequisite to an elementary course in speech a course in mental hygiene such as the one that Dr. Harry A. Steckel, director of clinical psychiatry at the Binghamton State Hospital, outlines in the July, 1928, issue of the *Psychiatric Quarterly*. If all the students who come to us could have such a course as a background, the task of the speech teacher would be greatly lightened.

At the University of Minnesota we hold two conferences each quarter with every student, and we spend much more time in private conference with those students who have marked behavior problems. It is customary for us to excuse a student from class if we think that for the time being it is best that he meet with the instructor only in private conference until he understands his speech problems. Then we send him to a new class before which he can make an entirely new adjustment, thus facilitating the conditioning process through which the student must pass.

We aim to secure a short case history of each student, and a detailed one of each student who shows marked manifestations of poor adjustment in the speech situation. By a study of the case history with the student in private conference, we try to help him to analyze the causes of his likes and dislikes, his home environment, his reactions in general to his parents, his prejudices, social fears, sex life and repressions, social philosophy, religious conflicts—in fact, all those factors that go to make up the sum total of his behavior patterns which are so completely manifested in his speech habits.

There is one great danger, however, that needs to be guarded against in the application of the mental-hygiene technique in the teaching of speech, and that is psychiatric quackery. The widespread interest in mental hygiene that has been aroused during the last few years has brought with it the popular fad of speaking the psychiatric vocabulary without understanding its meaning. Hence there are pseudo-scientists who harm not only the mental-hygiene movement, but injure the mental health of those whom they pretend to benefit.

It should be remembered that the speech profession at present contains a relatively small number of teachers who possess a sufficient background in psychiatry, psychology, mental hygiene, and child-guidance technique to be qualified to approach speech training from the point of view I have endeavored to set forth in this article.

There is a need, therefore, for teachers who are qualified to teach speech from the mental-hygiene approach, and when the speech departments of our universities train teachers who understand the value of mental hygiene to speech education, then, I think, elementary speech training will be academically more valuable than it is at the present time.

MENTAL HYGIENE AND THE PRACTICE OF MEDICINE *

EDWARD A. STRECKER, M.D.

Professor of Nervous and Mental Diseases, Jefferson Medical College

IT would be useless to deny that in the minds of many general practitioners there exists a very wide gap between the problems of psychiatry and their own direct and daily medical interests. It has been customary to attribute this absence of closer understanding and coöperation to the somewhat checkered career that psychiatry has had to pass through in order to reach its present position among the specialties of medicine. However, it is somewhat doubtful whether the mere fact that mental disease has been variously regarded as a theological, metaphysical, philosophical, and legal proposition can be made to shoulder the entire blame. In reality the gap between internal medicine and psychiatry is more artificial than real. It is remarkable how often something that is essentially good can be stigmatized by being given a bad name. Too often, the terms "lunacy" or "insanity" conjure up distracting visions of restraint, confinement, and violence; or, from the legal aspect, psychiatry is regarded as something in which one had better not dabble because of the liability involved. As a matter of truth, this is far from being the important feature of psychiatry, and as Pierre Janet remarked: "The word 'lunatic' is now a term of police language and indicates only an embarrassment felt by the police before certain persons' conduct."

A little reflection should make it clear that even if psychiatrists and internists desired to go their separate ways (which fortunately they do not) conditions would still make it impossible for them to do so. A great number of diseases that begin as problems of strictly internal medicine soon

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overflow into the channels of psychiatry, and vice versa. One need only mention the deliria of typhoid, pneumonia, and other infectious diseases, the mental states associated with lead and the metallic poisons, the various accompaniments and sequels of alcoholism and syphilis, the effect of well-known endocrine diseases on the functions of the mind. Furthermore, general practitioners are often excellent psychiatrists. It is curious how we may fail to recognize an old friend simply because he happens to be dressed in unfamiliar garments. For instance, some of the elements of so-called psychotherapy are contained in the everyday creed of the family doctor; yet when psychotherapy is presented as psychotherapy, he is apt to fight shy of it because he at once links the term with the mysterious and the occult. Every day physicians and surgeons are meeting all sorts of minor psychoses in their patients, and yet, far from being puzzled or alarmed, they recognize these conditions from experience as familiar manifestations and often deal with them in a highly successful manner.

In addition to the obstacles that may be said to result from a primary and correctable lack of understanding, there are other difficulties that are helping to postpone the day when the general practitioner will appreciate and perhaps be helped by the efforts of the psychiatrist. For several of these difficulties psychiatrists themselves are chiefly to blame. It is no secret that the language in which mental disease is frequently described and discussed is, to say the least, confusing and formidable. With the evolution of every specialty, there necessarily arises a special language for convenience of description, but if it becomes too involved and obscure, the busy physician will turn away from it in discouragement, or else he will feel, with considerable logic, that high-sounding words and phrases are often a cover for profound ignorance. There is no reason why the terms used in describing mental disease should not be as intelligible as those employed by the surgeon or the gynecologist. Again, certain psychiatrists with sincere, but regrettable enthusiasm have sought to emphasize one particular aspect of mental disease to the exclusion of everything else. It is true that

the psychogenetic aspect must be most carefully investigated, but it is likewise true that it does not constitute the sum total of psychiatry.

It is a good sign of medical progress that the principle of informal group diagnosis is being more and more freely applied to the study of obscure conditions. It is the expression of the progressive idea that symptoms need to be traced to their beginnings and that special knowledge may be required to do this. On such a basis the psychiatrist has a very attractive and feasible proposition to put before the medical profession. Very often in the patient who has mental disease we have simply a case for diagnosis. From such a broad point of view the general practitioner, as well as every brother specialist and laboratory expert, has something to contribute. At times there may be unusual and disquieting phenomena, which, however, should not confuse the issue. In the first place, they are perhaps somewhat less frequent than is commonly supposed, and in the second place, they should be no more successful in turning one from the investigation than are the disagreeable features of venereal disease. There is only one conception that is worth consideration and that is that so-called insanity is, after all, simply disease, and as such deserves the same careful and general medical attention as other diseases whose cause is in doubt, as, for instance, cancer.

What has psychiatry to give in return for the consideration and help that it seeks? The sooner knowledge of the principles on which it is based becomes diffused among the ranks of general practitioners, the sooner will they learn some very useful and valuable lessons which may be applied in their everyday practice. There is in every person who is sick, even though his illness be merely a cold in the head, an "X" quantity, an unknown factor that represents his peculiar reaction as an individual. Let me repeat that psychiatry has methods to impart that will make it possible and feasible to recognize and handle this factor. It has been well said that the correct way to study so-called normal behavior is to study the workings of the abnormal mind. The cry to-day is for prophylaxis and preventive medicine. No campaign

on a large scale for public health will reach its mark, which is presumably the raising of the standard of civilization, unless it recognizes that the human being has a mind as well as a body; nor will physicians who undertake the work of human physical betterment reach their full possibilities and worth until they come to this realization. Here, again, psychiatry has special knowledge and help to give.

Objections to psychiatry not valid.—Part of the failure properly to understand the true principles and aims of psychiatry may be traced to recent times. The physician is less concerned about the mind of his patient than he is about his heart, lungs, eyes, ears, nose, throat, or the potential surgery of his abdomen. It is sometimes asserted that the symptoms of mental disease are so disagreeable and disquieting that special hospitals must be provided, and that it is therefore difficult for physicians to retain their interest in it. There is also the complaint that methods of treatment must be so individualized that they have no application in other fields of medicine. Other objections are that in psychiatry etiology is largely unknown, and that, consequently, specific therapy is impossible, and treatment must be purely symptomatic; the legal aspects are said to be time-consuming and perilous; and, finally, the impression has gone abroad that in the field of psychiatry results are universally disappointing, and the laborer is not repaid for his efforts.

These objections are half-truths whose better halves are untrue. A moderate amount of reflection and explanation will dispose of most of them. For instance, other diseases, such as venereal affections, tuberculosis, and cancer, likewise have an unpleasant symptomatology, yet the profession continues to be vitally interested in them. Furthermore, the scientific trend is in the direction of particularized hospitals, and they are commonly utilized for the study and treatment of phthisis, contagious diseases, and malignancy. The question of therapy in psychiatry will be developed later, and it will be shown that far from being restricted to insanity, it has a wide range of usefulness. Progress in knowledge of the etiology has not been insignificant. The causation and pathology, and sometimes both, are as definite in paresis,

the alcoholic and drug insanities, certain occupational and industrial psychoses, senile and arteriosclerotic dementias, fever deliria, some of the endocrine dyscrasias, as they are in nephritis or organic heart disease. In addition, we are now somewhat nearer to a measurement of the results of somatic and psychogenic stress and strain. It is scarcely necessary to recall that the absolute specifics available to the internist are extremely few in number, and that therapy is still largely confined to the intelligent correction of symptoms plus the healing effect of time. The fear of legal entanglements is to some extent a scarecrow. The percentage of cases that may give rise to trouble in this respect is relatively small and may be readily recognized and avoided; and one is in the long run as apt to be sued for the management of diphtheria or Colles' fracture as for a certificate of insanity. Finally, the issue of prognosis has been misrepresented. Between 60 and 75 per cent of the psychoses, which are comparable to what the internist would designate as "acute", are recoverable, and in internal medicine large groups, such as certain types of cardiac, vascular, and renal disease, or tuberculosis and carcinoma, are both quantitatively and qualitively comparable to the chronic residuum of psychiatry.

Relation of psychiatry to the practice of medicine.—Conversely, psychiatry has a very definite contribution to make to internal medicine. Even if this did not go beyond the recognition and emphasis of that elusive, but highly important factor, the psychic element in somatic disease, how valuable a contribution it would be! It is not an overstatement to say that fully 50 per cent of the problems of the acute stages of an illness and 75 per cent of the difficulties of convalescence have their primary origin not in the body, but in the mind of the patient. Psychiatry has methods to impart that will make it possible and feasible to recognize and handle this factor. This is the age of efficiency. The maximum of effort must be directed against the point of greatest resistance, and waste must be reduced to a minimum. On every side there is the cry for greater medical and surgical efficiency, elimination of fruitless motion, reduction of the number of hospital days, shortening of convalescence within limits of safety, and eco-

nomic utilization of the partially disabled. A tremendous gain in every direction will be sure to result if internists will appreciate the psychopathology of the patient and his illness, and treat it as energetically as they do his dangerously high fever or his circulatory collapse.

For the sake of convenience, anatomy studies the body as separate organs and systems, while academic physiology takes up the individual function of those organs and systems. At the bedside and at the post-mortem table, such limited conceptions are swept aside, and we are made aware of the enormously complicated and connected relationships in anatomic structure and physiological dependence. Likewise, it is customary to think of disease in terms of the various hypothetical levels affected, such as, for instance, the structure level, the chemical level, the psychic level. Such distinctions are largely artificial, and in disease we are almost always dealing with total reactions which are the result of the constant interplay between individual and environment. Herein is the nucleus of the broad etiologic considerations that psychiatry studies and that are equally applicable in the field of internal medicine. In reality there is no such thing as absolute, unconditioned specificity. If contact with, or exposure to, the bacillus of tuberculosis inevitably meant the development of consumption in an individual; if the mere presence of the bacillus of pneumonia, the spirochete, or the typhoid bacillus must always have as a necessary outcome pneumonia, syphilis, or enteric fever, then the human race would long since have disappeared from the earth. In all probability the processes that lead to the development of any morbid condition are immensely complicated and closely related to one another, and disease is almost always the culmination of a long series of more or less detrimental or destructive conditions which eventually become sufficiently strong to break down the barriers of natural and acquired resistance. Such destructive conditions may be physical or psychogenic, rarely ever occurring in isolated form, but one intermingled with or closely following another. Thus a period of pronounced mental strain may disorganize the endocrine apparatus, with resultant exophthalmic goiter,

which in time may give rise to mental symptoms. Likewise, years of constant mental stress may lower the resistance to the point of pathologic fatigue, which may eventuate either in acquired neurasthenia or in actual organic pathology. In the disease itself the infecting agent or the toxin may expend itself chiefly on the gross structural organism or it may express itself by mental complication and sequels. Epidemic encephalitis furnishes a typical example. The patient may be left with a permanent Parkinsonian syndrome, but clear mentally; or he may be neurologically intact, but present abnormal behavior practically amounting to criminalism. Enteric fever may run a smooth course without complications, but again hemorrhage or peritonitis may occur, or there may be essentially a psychosis with grave delirium and possibly meningitic signs. Why these differences? While we know that in any disease the severity of the infection is influential, we must also know that there are other influences. In the last analysis, is it not feasible to weigh in the balance the whole life history of the patient and even to take into consideration remote, perhaps ancestrally determined strengths or weaknesses of the various systems of the body, such as the circulatory or nervous? This is the philosophic conception of etiology which psychiatry particularly emphasizes.

It is unfortunate that there is not more real understanding of the therapeutic methods of psychiatry. Either they are thought to be mysterious and almost occult, or else it is assumed that actual treatment does not exist, and the patient gets well or worse without let or hindrance from the physician. Both notions are wrong. Part of the treatment that psychiatrists employ may be classed as psychotherapy. This may be roughly defined as getting at the psychopathology of the patient and his illness and correcting it as far as is possible. This does not imply the use of any psychic sleight of hand, of any tricks, or any complex formulæ and practices. Psychotherapy is utilized more or less unconsciously, sometimes awkwardly and sometimes skilfully, by internists, surgeons, and by practitioners in every specialty of medicine. Psychiatrists are merely attempting to reduce it to feasible and practical limits, and realizing its value as a therapeutic

weapon, they strive for deliberate, carefully aimed effect, instead of trusting to accidental and often ineffectual thrusts.

The remainder of psychotherapy is largely symptomatic and as such is comparable with the bulk of the treatment that the internist carries out to such good purposes. However, in psychiatry, too, from the necessity of an intensive attack on certain critical situations, improved forms and technic of active treatment have been evolved. Some of these forms and some of this technic can be carried over directly into internal medicine with considerable benefit. No criticism is intended by the statement that the febrile and toxic deliria do better in a mental than in a general hospital. In the latter there is still a tendency to be somewhat disconcerted by the motor and vocal activity of the patient and to prescribe restraint and narcotic drugs; in the former the emphasis is on free elimination, fluid intake, and sleep procured by agents other than opiates. Certain developments of hydrotherapy, particularly the continuous bath, would have a wide range of effectiveness in the general hospital and even in the private home. Neurologists and psychiatrists were the first to insist on the potency of rest in bed, isolation, overfeeding, massage, and electricity. It is still necessary to teach that these measures must be administered not haphazardly, but as exactly and carefully as is a hypodermic injection of morphine. Occupational therapy, not as a pastime, but as a successful means of hastening recovery and establishing readjustment, is now receiving flattering recognition from internists. It should now be clear that instead of being inanimate, the therapy of mental disease is alive with actual help and potential suggestion, which with little modification will increase the resources of internal medicine.

The psychic factor in somatic disease. — To discuss the many situations that could be the better handled if the physician and the surgeon utilized the teachings of psychiatry more generally would expand this paper beyond its proper limits. In order to be as effective and as practical as possible, it will be necessary to restrict it to a brief consideration of certain points that are too often insufficiently stressed or even wholly neglected. The chief point concerns the

psychic factor in somatic disease. Even if the physician or surgeon is so fortunate, or so unfortunate, as never to be required to see a case of outspoken mental disease, he should never forget that the sick individual has a mind as well as a body, and that the course and outcome of the organic morbid process is tremendously influenced by the mental attitude of the patient. Psychiatry teaches and demonstrates that this attitude can be controlled by the physician and directed into helpful channels, but the essence of the psychiatric dogma is that man is something more than the sum of his parts or organs; that this something more is of the utmost importance, not only in health, but particularly in disease, and that the physician must not treat this or that symptom or all symptoms, *but must treat the patient.*

The field is so extensive that it is impossible to be specific. As an illustration, however, two incidents that came to the author's attention recently may be cited. While visiting a large and thoroughly modern hospital, he noticed a patient who was about to be wheeled from the ward to the surgical operating room. Seemingly, in the hurry and bustle of preparation, everything had been remembered *but the mind of the patient who was about to pass under the knife of the surgeon.* No one silenced the facetious remarks of the other patients, though the ashen face of the patient on the ward carriage made it obvious that he was in the grip of deadly, blind, unreasoning fear, and that this emotional crisis would lessen his chance for a satisfactory anethesia and a speedy recovery.

Some months later the author visited a small hospital, far away from any great medical center, but with a noted surgeon on its staff. Here, also, a patient was being prepared for operation. He was in a quiet, cheerful room, and was listening to the reassuring conversation of the anesthetist. The surgeon found time to drop in, and in his presence and words were strength and confidence. As the ether was administered, a music box was turned on, and the patient passed into unconsciousness quietly and peacefully.

At the weekly staff meeting in this small, but excellent hospital, an attempt is made to identify the most dissatisfied

and disgruntled patient. This individual then becomes the unsuspecting recipient of innumerable little favors and attentons at the hands of every one, from the chief surgeon to the humblest probationer nurse. Invariably the grouch is removed, and the patient becomes enthusiastic in his praises and support. It is obvious that the head of this institution is a firm believer in the principles of psychiatry.

The mental vicissitudes and emergencies of any illness usually outnumber the purely physical. Often the patient is uncertain and apprehensive. Not infrequently he is irritable and unreasonable. Many times he is "blue" and depressed and may readily sink into the very depths of despair. Almost always these unhealthy emotional reactions are reflected in the falling barometer of the general condition. The physician who appreciates the lessons of psychiatry will want to trace these phenomena to their sources. There may be destructive influences in the atmosphere of the sick room that need to be corrected; there may be friction in the household that should be eased. A sick person is remarkably sensitive to such disturbing influences. It may be that the trouble is wholly in the mind of a patient and a frank talk may save unnecessary suffering. The physician who is also a psychologist and mental hygienist will know when to be gay or grave, casual or explicit, firm or lenient, when to praise or chide. These and many other things are implied in the psychiatric management of the case. Physicians who feel it worth while to do this and do it with the proper technic may anticipate as a reward the highest measure of professional satisfaction and success.

Convalescence.—Convalescence from any serious illness is overwhelmingly a problem of psychiatry. The acute drama of the sickness is over, and the actual danger is safely past. There remains only the tedious and irritating return to complete health and strength. Roughly, convalescents fall into two groups: in the first is the patient who is impatient of the slightest delay, who wishes to run before he can walk; in the second is the potential neurasthenic whose illness may have been a long and exhausting process, but had its pleasant features in unlimited interest, care, and

attention, which now have ceased. The patient is still weak and miserable, but seemingly he is expected to "get on" rapidly and soon be ready to take up once more the strife and stress of the struggle for existence. Small wonder if he sometimes "holds back" unconsciously and retains a few symptoms. After all, it may be "nice" to keep the center of the stage a bit longer. In this way the neurasthenic is sometimes made.

It is curious to note that at times even skilled internists fail to cope with the convalescent patient. Here, again, there is need of the psychiatric point of view. Within reason the retention of the "sick stage" must be made unattractive to the mind of the convalescent, and the advantages of a return to perfect health must be subtly emphasized. Here, again, the physician must be in turn many things. He must be direct and subtle, firm and lenient; he must know how and what to suggest and when to suggest it; he must be ready to take advantage of every favorable incident and circumstance, and to minimize untoward happenings. The difference between his willingness to consider or disregard convalescence as a mental problem is often the difference bewteen a completely recovered patient and one who will remain handicapped for years or even for the remainder of his life.

"Acute" and "chronic".—For some reason, perhaps related to a defect in our system of medical education, the young physician is apt to begin practice dominated by what might be termed the fetichism of the "acute". In other words, he is likely to regard acute disease as something glorious and well worth his attention, but is apt to dismiss chronic disease as more or less uninteresting. Such a point of view is wholly fallacious. In the first place, acute illness, by which is implied a pathologic process in which a complete restoration to the former state may be achieved, is quite rare. Exclusive of some of the infections of childhood and a very few in adult life, few examples can be cited. On the other hand, the so-called chronic diseases, in which improvement, but not absolute recovery, may be anticipated, are legion and make up the bulk of everyday practice. One

has only to consider the host of heart, circulatory, kidney, liver, and nerve involvements in which there can be no hope of restitution *ad integram*. It is entirely reasonable to say that the drift of patients of certain types toward various "isms" and charlatanry is in part due to the fact that it is difficult to arouse in some physicians enough enthusiasm and interest in the treatment and management of chronic organic sickness. The charlatan professes an interest and promises the impossible, and is often a liar and a cheat, but he does recognize the value of mental therapeutics.

Mental hygiene has always emphasized the necessity of applying psychotherapy to the mind of the individual whose life is limited and hampered by chronic pathology. Legitimately and honestly there is much to be accomplished here. If hope and coöperation are kept alive, and pessimism and despair prevented, amazing physical improvement can be secured and maintained for long periods of time. This involves an intelligent study of the patient and of his physical, mental, and environmental state, followed by an earnest effort to secure the most satisfactory adjustment. The conservation and utilization of brain power to be found in those who are suffering from such conditions as chronic cardiovascular and renal degenerations, tabes, the sequels of cerebral hemorrhage, or what not, has, in many instances, conferred enormous benefits on civilization.

Mental hygiene at critical life periods.—The ideal physician is the intimate and often the father confessor of his patients. In this rôle he is sure to come into contact with the struggles and anticipations, the fears and the aspirations, that are occasioned by the natural and accidental crises of life. Childhood, puberty, and adolescence; heterosexual love, marriage, pregnancy, and child-bearing; the climacteric, middle age, old age, and other episodes and experiences usually imply serious physiologic, particularly psychologic upheavals, and if help is withheld at these critical times, the result is often disastrous.

Every crisis in the life of a human being is a golden opportunity for mental hygiene. The physician must seize the opportunity and use it advantageously and must be willing

to make the attempt to look not only into the body of his patient, but into his mind as well. Furthermore, he must know the environment in which the patient lives and moves. No scientist would be guilty of trying to interpret the behavior of a laboratory animal without a consideration of the surroundings of the animal. Nevertheless, from time to time one is confronted with the belief that the doctor should not inquire too closely into the personal life and affairs of his patients. A prescription for bromides will not cure a neurosis that is due to abuse from a drunken husband; a bottle of valerian will not remove a depression of the climacteric which is being augmented by domestic friction and misunderstandings; the coal-tar products will not permanently alleviate the headache that may be an expression of worry about a wayward son; nor will a circumcision change sexual impotency into potency in a young married man who is burdened with a sense of inferiority because of an unfortunate early environment. It is tragic to reflect that often the real difficulty is almost at the surface, but for want of a bit of tactful probing, is unrecognized; that simple problems are left unsolved and perpetuated as hopeless and chronic affections. The habit of careful inquiry into the mental aspect of conditions that may come to view as casual bodily symptoms, and a sympathetic analysis of the environment, will pay unforeseen dividends to both patient and physician. Once it becomes customary to do this generally and properly, fewer minds will be wrecked on the rocks of puberty and adolescence; the complete experience of heterosexual love will less often prove disappointing and even revolting; marriage will not end so frequently in blasted hopes and human wreckage; many of the terrors of pregnancy and child-bearing, including some of the so-called "physical" ones, will vanish; the psychologic reverses of the climacteric will no longer be regarded as inevitable; the middle years of life will not merely be the beginning of physical and mental monotony or worse; and even old age will be robbed of some of its mental hazards. Surely the goal is a splendid one, and to a very considerable degree its attainment is in the hands of the doctor.

The physician and functional disease.—The term "functional disease" is used because the problem embraces much more than the classical neuroses — hysteria, neurasthenia, psychasthenia, and the anxiety neurosis. The author is willing to risk the criticism invited by the statement that the general physician should and must treat functional illness. In the first place, it is so common that only a small fraction of it will come to the attention of the specialist. In the second place, functional phenomena in many instances are so closely interwoven with the symptoms of acute somatic pathology that any accurate separation and labeling of the exact nature of the case is out of the question.

It is interesting to attempt to trace what happens to the patient who presents himself to his family physician and who is entirely or predominantly sick, not in his organs, but in his functions. In a considerable number of cases, the physician's attention is engaged by the physical expressions of the basic functional disturbance. These physical expressions are innumerable and include such everyday symptoms as headache, nausea, vomiting, gastro-intestinal or cardio-circulatory complaints, and so on. If the treatment is directed solely at the deceptive surface symptoms, the result will be failure or at most very slow and indifferent progress. Again, the physician will recognize the essential functional complexion of the situation, but for lack of confidence, or occasionally for want of interest, he will deal with it in a hesitant and vacillating manner. The resultant unsatisfactory reaction of the patient is apt to increase his uncertainty or deepen his boredom, and the patient is referred to another practitioner or perhaps treatment is continued on the basis of stereotyped prescription writing. All this is of the greatest practical importance to the physician, since it is conservatively estimated that 70 per cent of his daily work is concerned with functional, and not organic, pathology. Fortunately, a large proportion of the medical profession is alive to the value of the application of psychiatry and mental hygiene to their professional problems.

A plan of treatment.—The management of functional conditions is within the scope of every intelligent practitioner.

In some instances help may be needed when the mechanism is quite complicated, and in some unusual cases the help of the specialized technic of the neuropsychiatrist may be needed, but the bulk of the work can be done—indeed, must be done—by the family doctor.

The plan of therapy is purposely elastic, for it seems that it would be a serious mistake for the physician to attempt to practice by rote. Not only the personality of the patient, but also the personal assets of the physician will determine many modifications in the line of therapeutic attack.

The physician must remember that treatment of the neurotic patient begins at the first instant of contact. Hurry, carelessness, impatience, unwillingness to make case notes, not only deprive the physician of needed knowledge, but also prevent the establishment of proper relations with the patient, without which nothing constructive can be accomplished. It is customary to state in textbooks that the attitude of the physician should be strictly impersonal. Fortunately, it is practically impossible to acquire such an attitude. It implies remoteness and detachment, or at best a cold intellectual curiosity, while in reality what is urgently needed is warm interest in the difficulties of the sick individual. Such interest is not maudlin sympathy, but it does have an emotional element, without which little progress can be made.

History taking. — An important part of treatment is history taking. This may be conveniently divided into the family history, the history of the patient, the social-environmental history, and the history of the neurosis. It is often good practice to devote a preliminary period to listening to the account of the nature of the presenting symptoms. The patient is apt to be tense, worried, anxious to unburden himself, and he will obtain a certain measure of relief in being able to describe the troublesome symptoms. It is advisable to let the patient "talk himself out", not only at this time, but also when he is giving the several divisions of the history. Should he become too circumstantial, it will not be a difficult matter to turn him back to the main thread of the narrative. However, it is not the part of the physician

to make too many suggestions or to supply missing links in the chain of the historical account. It may be recognized as incomplete, however, unless the doctor emerges from the interview with a clear mental picture of the ancestry of the patient; of his previous life, in which there are always factors to be found that have influenced the development of the neurosis; and of his social-environmental relations, in which likewise there are to be discovered maladjustments that may have a bearing on the pathologic situation.

The history of the neurosis usually needs to be exhaustive. The patient should try to assign a date (which is usually not the actual date) for its beginning. The setting, immediately personal and environmental, that existed at that time should be closely scrutinized. Each major symptom should be retrospectively reviewed from the time of its initiation, and the incidents within and without the patient that heralded its appearance should be noted. The patient should be invited and encouraged to give his opinion concerning causal factors. Statements such as, "I don't know of any", should not be permitted to pass unchallenged. He should be urged to recollection and to venture an explanation. All this is not analysis—it is merely history taking, which frequently uncovers valuable clues. Whether or not an exploration of the unconscious mind is contemplated, there is always important material in the conscious mind, or within the mental territory open to recollective effort, which may be had for the asking.

Physical examination.—There are at least three reasons why the physical examination should be thorough to the point of employing every useful diagnostic procedure, including the skill of the internist, instruments of precision, and the clinical laboratory. In the first place, dynamic somatic pathology may be and often is uncovered; in the second place, the examination in itself, if it is a searching one, has a beneficial effect on the patient; and in the third place, it puts the physician in an advantageous and authoritative position for the future management of the case. Secure in the accurate knowledge he has acquired concerning the

physical status of the patient, he is able to weight properly the numerous subjective phenomena that present themselves.

Conclusions on the basis of former findings. — The next therapeutic step chiefly concerns the physician. He has now obtained sufficient information to enable him to formulate the situation and to decide on a concrete plan of attack. He must find out what is the apparent genesis of the neurosis; the relative weights of the psychogenic, somatic, and environmental factors. He should ascertain if the organic situation is serious enough to indicate hospital treatment, or if rest-house treatment would meet the case; if the psychogenic aspect is of the type to be analyzed, or would it be safer for the physician to limit himself to simple explanation, persuasion, and suggestion? He must also decide whether environmental-social elements are serious and destructive, or capable of correction. He must form an opinion on all these points; otherwise his study of the patient has been incomplete and faulty.

The authoritative interview with the patient.—At this time the physician is not seeking information, but is giving his conclusions. Rash promises should be avoided, but lack of confidence is fatal. As much frankness as is permissible in the circumstances of the individual case is highly desirable. Details need not necessarily be given, but the patient should be made to understand the main issues. For instance, there are certain physical liabilities that need to be corrected; or there are certain psychogenic situations that need to be probed further and worked out with the patient so that he may understand their significance and be given the right attitude that arises from self-knowledge. There may be social-environmental friction against which the patient has been blindly rebelling, and it is necessary that he be given the correct point of view toward them so that their deleterious effect may be minimized. If the patient is willing to coöperate and put himself unreservedly into the doctor's hands to do as he asks, the physician may state that he believes he will be able to cure him. In this way the ground is cleared for effective action.

The details of treatment are matters of universal medical

knowledge. Some of them will be found useful in every case—hospital or rest-house care, rest in bed, scientific nursing, dietary control, massage, hydrotherapy, electrotherapy, occupational therapy, supervision of the patient's activities (including visitors), correspondence, reading, graduated exercise, tonic, and in extreme conditions hypnotic medication, and so forth. Above all, there must be correction of any actual organic pathology. The majority of these measures are within the field of ordinary medical practice. However, it must be stated that the way in which they are usually administered renders them ineffective and useless. There must not be anything haphazard or uncertain about any detail of treatment. They are exact therapeutic procedures, and if not given exactly and precisely, they not only lose their intrinsic curative significance, but also the added psychotherapeutic value that they possess.

PSYCHOLOGY AND PSYCHIATRY IN INDUSTRY

THE POINT OF VIEW OF A PSYCHOLOGIST *

MORRIS S. VITELES, PH.D.
Assistant Professor of Psychology, University of Pennsylvania

THE chief purpose of this paper is to discuss psychology from the point of view of aims, methods, and philosophical foundations with a view to demonstrating the part that it is fitted to play in discovering what Persons[1] has designated as "the causes of conduct or fundamental laws for the guidance of management in influencing conduct" in industry. Such a discussion will necessarily entail a description of investigations in industry from which the nature of the accomplishments of psychology in this field can be seen, and on the basis of which predictions concerning further developments can be made. A description of these investigations will, in addition, make it possible to achieve another purpose in this paper—that of distinguishing between the psychological and the psychiatric approach to problems of human behavior in industry.

No attempt will be made here to discuss in detail the meaning of psychology and its aims. It will be assumed that all to whose attention this paper may come are familiar with the definition of psychology as "the science of human behavior" and in addition have some familiarity with the various psychological systems. There seems on the whole little disagreement between the psychologist and the psychiatrist as to the scope of a scientific approach in the study of human behavior. There is unquestionable agreement to the effect that human behavior should be studied in all its aspects, with a view to formulating principles that can be used to explain individual behavior and to assist in the adjustment of individuals whose behavior is incompatible with complete adaptation.

* Read at a meeting of the Associated Industries of Massachusetts, Boston, April 30, 1928.

1 "Industrial Psychology", by H. S. Persons. *Bulletin of the Taylor Society*, Vol. 9, pp. 163–71, August, 1927.

It is true, as will be pointed out later, that in the accomplishment of this aim psychiatry and psychology have adopted quite distinct methods of attack. Moreover, the early investigations of psychology were limited to the study of more or less restricted phenomena of human behavior, such as those of range of attention, discrimination of weights, rate of tapping, coördination, and similar psychomotor responses. But, from this early insistence upon such restricted phenomena as units of observation in psychology, there has been a gradual expansion in point of view to include the behavior of the whole individual in diverse situations. The establishment of a psychological clinic as early as 1896, the influence of psychology upon education, and so forth, reflect this broadening of interest.

It is likewise probably true that from its very beginning psychiatry concerned itself with the whole individual, and with what Mayo [1] has so aptly termed the "total situation", but in the study of human conduct in industry, regardless of the methods employed, there can *at present* be said to be little difference in the general aim of the psychologist as compared with that of the psychiatrist.

The outstanding difference between the psychiatric and the psychological approach in industry is one of method. The method of the psychiatrist has been adequately described elsewhere. I shall, therefore, limit myself in the main to a discussion of psychological methods as illustrated in a number of investigations by psychologists in industry. It seems well to start with an account of some of these investigations, and then proceed to a more general discussion of differences in method between psychology and psychiatry.

The most important contributions of psychology to industry in this country have been in the field of vocational selection—in the development of psychological tests for the selection of competent employees. It might be expected, therefore, that the major portion of this paper would be devoted to an account of investigations of this type. It seems fair, however, to assume in my readers sufficient familiarity with work of this kind to permit me to refer only briefly, at a later time, to

[1] "The Basis of Industrial Psychology", by Elton Mayo. *Bulletin of the Taylor Society*, Vol. 9, pp. 249–59, December, 1924.

psychological studies of vocational capacity and to devote the major portion of this descriptive section of my paper to other types of investigation which have to a great extent occupied the attention of European psychologists, and to a lesser extent that of psychologists in this country.

The first of these is a group of studies dealing with *accidents in industry*. According to Stephenson,[1] an English investigator, it has been estimated that at the present time about one-third of industrial accidents are attributable to the use of machinery and not more than one-third of these machine accidents to the absence of guards, leaving about 90 per cent of present-day accidents to be accounted for as failures of the human subject. The importance of investigations into the causes of this human susceptibility to accidents cannot be overestimated.

Representative of the approach of the psychologist to the study of this problem is a series of statistical studies by Marbe,[2] a German psychologist, who demonstrates the importance of the personal equation by figures showing that the individuals who suffer accidents are more likely to be involved in accidents in succeeding years than those who have never been involved in accidents. Individual differences in proneness to accidents are likewise demonstrated by an English investigator, Newbold,[3] who made a thorough statistical analysis of accidents to factory workers in thirteen plants. The consistent presence of individual tendency to accidents is shown by a correlation not only between accidents in two different periods, but also between accidents of one type and those of another, and between accidents in the factory and in the home. The relationship between accidents in the factory and in the home has implications as to the interaction of response on the part of the individual in the home and in the factory that must be taken into consideration in investigating the causes of human conduct in industry. Incidental to New-

1 "Accidents in Industry", by A. Stephenson. *Journal of the Institute of Industrial Psychology*, Vol. 2, pp. 194–200, October, 1926.

2 *Practische Psychologie der Unfälle und Betriebschäden*, by K. Marbe. München: R. Aldenbourg, 1926. 110 p.

3 *A Contribution to the Study of the Human Factor in the Causation of Accidents*, by E. M. Newbold. Industrial Fatigue Research Board Report No. 34. London: His Majesty's Stationery Office, 1926. 74 p.

bold's investigation, as well as characteristic of studies by Schmitt,[1] Bloss,[2] Muscio,[3] and others are findings on the influence upon accident rates of age, of experience, of such conditions as weather, hour of day, and so forth, and data on the effect of rate of work as compared with that of fatigue, which are fundamental to a complete understanding of the causes that underlie accidents due to the human factor in industry.

Statistical studies of this type are supplemented by inquiries into the influence on accident rates of individual differences in specialized mental abilities and temperamental traits. Chief among these is a recent psychological study of individual differences in accident rates, by Farmer and Chambers,[4] showing a difference of 48 per cent in accident rates between individuals scoring above and those scoring below the average in a series of psychomotor and other tests, as well as other findings that lead to the conclusion that inequality in accident liability is determined not solely by chance, but by differences in traits measurable by objective tests. The experimental procedure of this and similar investigations shows the influence of the psychological laboratory on industrial investigations conducted by psychologists and the extent to which conclusions are based on objective, factual data which are basic to a scientific study of the principles that underlie accidents, as well as other forms of human behavior in industry.

A problem possibly equal in importance to that of accidents is the influence of *monotony* upon human behavior in industry. Much has been written by economist, sociologist, psychologist, psychiatrist, professional reformer, and professional agitator upon the effects of loss of interest through repetitive work upon production, upon the genesis of industrial strife, and so forth. Many are the diatribes and polemics upon this

[1] *Unfallaffinität und Psychotechnik im Eisenbahndienst,* by E. Schmitt. *Industrielle Psychotechnik,* Vol. 3, pp. 144–53, 363–66, December, 1926.

[2] *Zur Psychologie des Eisenbahnunfalles,* by Bloss. *Industrielle Psychotechnik,* Vol. 3, pp. 353–63, December, 1926.

[3] *Two contributions to the Study of Accident Causation.* Industrial Fatigue Research Board Report No. 19. London: His Majesty's Stationery Office, 1922. 36 p.

[4] *A Psychological Study of Individual Differences in Accident Rates,* by E. Farmer and E. G. Chambers. Industrial Fatigue Research Board Report No. 38. London: His Majesty's Stationery Office, 1926. 46 p.

subject, but it has been left to the psychologist to develop an experimental, scientific procedure in the investigation of this problem which has led to significant conclusions not only as to differences in the reaction of individual workers to repetitive work, but as to the multiplicity and nature of the factors that underlie these differences. An illustration of psychological experiments in this direction is a laboratory investigation conducted by Burnett[1] in which four unemployed girls were engaged for two months in the daily repetitive work of cross-stitching. Of these four girls two had been rated by an intelligence test as highly intelligent, the third showed average intelligence, and the fourth was distinctly below average in intelligence. The two most intelligent girls, although capable of reaching a high output from time to time, proved unable to maintain it and showed unmistakable signs of boredom in restlessness, yawning, frequent change of posture, and so forth. It is not to be contended from the results of this single investigation, or of others similar to it, that intelligence is the sole factor in monotony, but the demonstration that it plays a part in some cases at least represents a distinct contribution toward the solution of this difficult problem.

The question of differences in the reaction of individuals to repetitive work has been investigated by a number of German psychologists also. Winkler[2] compares, under carefully controlled conditions, the effects of repetitive work upon nine subjects who were accustomed to it and upon twenty-one subjects who were not accustomed to it. An analysis of the work curves of these subjects leads to conclusions as to the nature of individual differences in reaction to repetitive work, and as to the factors that underlie these differences, that are of extreme significance in their bearing upon the adjustment of individual workers in industry.

In this connection it is interesting to note the claim[3] "that a special form of work curve is apt to occur in monotonous work, the worker coming to it fresh at the start of the spell,

1 For an account of this experiment, see *Industrial Psychology in Great Britain,* by C. S. Myers. London: Jonathan Cope, 1925.

2 *Die Monotonie der Arbeit,* by A. Winkler. *Schriften zur Psychologie der Berufseignung und des Wirtschaftsleben,* Vol. 19, March, 1922. 45 p.

3 See *Industrial Psychology in Great Britain,* by C. S. Myers. London: Jonathan Cope, 1925.

then becoming bored with it, and finally looking forward to its termination as the end of the spell draws near. The curve of monotonous work, if this claim be substantiated, falls in the middle of the spell and is higher on either side of it, thus being absolutely inverse in shape to the 'normal' work curve, which reaches its maximum not far from the middle of the spell of work."

On the basis of another intensive investigation involving repetitive manual work under controlled conditions, Wunderlich[1] describes three distinct types of reaction to repetitive work, including one in which the whole rhythmic mechanization is completely freed from the control of consciousness, which can be directed toward other, and in many instances, pleasant ideas, as well as the type in which there is a pronounced unpleasant feeling of conflict and loss of interest, which may be described as monotony.

Another type of investigation—one in which the effect of a variation in work is compared directly with the effect of uniformity—has been carried out in connection with the packing of drugs in the shipping room of a manufacturing concern.[2] Three schedules were followed in work. In one the drugs were assembled, counted, packed, and wrapped by each worker; the second involved a change in occupation every half hour; in the third the same work was done throughout the day. From the point of view of rapidity and accuracy of work, the schedule involving many changes was found to be least efficient, but observations on the part of the investigator and introspective reports led to the conclusion that " repetitive work throughout the day was conducive to fatigue, boredom, and monotony".

The results of these psychological studies of monotony are far from conclusive and complete, but they illustrate the experimental method of psychology and suggest, at least, that, for example, Mayo's[3] contention "that monotony becomes a problem for the management of a concern only when it is

[1] *Die Einwirkung Einförmiger Zwangslaufiger Arbeit auf die Persönlichkeitstrukten,* by H. Wunderlich. *Schriften zur Psychologie der Berufseignung und des Wirtschaftsleben,* Vol. 31, 1925. 53 p.

[2] See *Applied Psychology,* by A. T. Poffenberger. New York: D. Appleton and Company, 1927.

[3] *Op. cit.*

obviously giving rise to pessimistic revery, not merely in individuals, but over a wide area of the personnel'' represents entirely too naïve a conclusion with regard to this industrial problem.

The contribution that psychology has made to education through its analysis of the learning process has become common knowledge. Equally significant—from the point of view of what can be accomplished, if not from that of what has already been done—is the application of psychology in training workers. The general principles of habit formation developed by the psychologist on the basis of laboratory experimentation have already been applied and can be applied further with promise of great return. A decrease in length of the training period and a decrease in the number of accidents have been ascribed by Tramm[1] in part to the application of these principles in training motormen. In my own work, complete reorganizations of training courses for motormen have followed a demonstration of the extent to which habit interference was permitted to play a part in the instruction of these workers.[2]

Only a few additional investigations illustrating the nature of the psychological approach in training workers will be mentioned here. Berling[3] has used practice curves on such operations as filing, tapping with a hammer, making micrometer readings, and so forth, in training metal-trade apprentices. The application of psychological principles in training crane operators resulted in a saving of 30 per cent in the time required to perform a stated task. And findings of the psychological laboratory as to the ''whole'' and ''part'' methods of learning have been transferred by Finck[4] to the factory in an investigation involving 36 apprentices in the metal trades. Other investigations of the same sort could be cited. It would also be possible, and perhaps desirable, to discuss psycho-

1 *Die Rationelle Ausbildung des Fahrpersonals für Strassenbahnen auf Psychotechnische Grundlage,* by K. A. Tramm. *Praktische Psychologie,* Vol. 1, 1919.

2 ''Transportation Safety by Selection and Training'', by M. S. Viteles. *Industrial Psychology,* Vol. 2, pp. 119–28, March, 1927.

3 *Planmässiges Einführung des Menschen in den Industriellen Arbeitsablauf,* by G. Berling. *Industrielle Psychotechnik,* Vol. 3, pp. 79–86, March, 1926.

4 *Anlernung im Ganzverfahren und im Teilverfahren,* by E. Finch. *Industrielle Psychotechnik,* Vol. 3, pp. 212–16, July, 1926.

logical investigations along other lines, but enough examples have been given to illustrate the distinctive methods employed by psychology in investigating the principles that underlie the causes of human conduct in industry.

A survey of these investigations shows *that the outstanding characteristic of the psychological method is its objectivity.* In this respect psychology shows the influence of physics and biology, the sciences with which it is in most intimate association. The psychologist has learned from workers in these sciences to depend as far as possible upon objective examinations of the phenomena of behavior under the same controlled conditions as the physicist uses in his objective observations of the behavior of inorganic matter, and the biologist in observing the reactions of living organisms. Controlled conditions, objective methods of measurement, and statistical treatment of mass data with a view to arriving at underlying principles is as characteristic of the science of psychology as it is of those of physics, of chemistry, and of other so-called older sciences.

The insistence upon objectivity is well exemplified in the laboratory experiments performed by the psychologist, only a bare reference to which need be made here. Whether he is observing the range of apprehension of a human being, his ability to memorize and recall, the influence upon the knee jerk of certain sorts of mental and physical activities, or bodily changes that accompany emotional states, the psychologist uses as far as possible the controlled conditions and the objective standards of evaluation that are characteristic of a truly experimental approach. This point of view he carries from his laboratory into industry.

It is in this respect that psychology differs most from psychiatry. The psychiatrist still leans heavily upon uncontrolled conditions; upon observations not subjected to careful measurement; upon interpretations of mass data that may be too largely influenced by a point of view representing rather the bias of the individual worker than a general principle subjected to verification through controlled observation of random, unselected samplings.

The objectivity of the psychological approach, as contrasted with the psychiatric approach, reveals itself particularly in

the measurement of individual differences in personality. The adjustment of the worker in industry involves at all points a complete study of individual personality. An adequate picture of the worker's talents and defects, his tempermental qualities, obtained either during the process of selection or after employment, is often the key to the satisfactory adjustment of a worker both from the point of view of efficient production and from that of the happiness of the employee. The psychological test for measuring human character reflects the objective point of view of the psychologist. Dissatisfied with the unstandardized, subjective judgments on human personality used by the physician in the diagnosis of feeblemindedness, he developed a standard, graded instrument for the measurement of intelligence, capable of administration under controlled conditions and of objective scoring. It is not my intention to discuss here the history of these tests, or the instances in which such tests have been used with marked success in determining mental ability and defect for industrial purposes. The work of Johnson O'Connor in the development of tests for apprentices, the motorman selection tests used in Milwaukee,[1] the work of Snow[2] and of Wechsler[3] on cab drivers, the numerous German and English investigations along the same lines are known to all who are interested in problems of vocational adjustment. It is merely my purpose to point out that the psychological approach in the examination of human competency is an objective one, subject to the same checks as the testing techniques of other sciences.

In this respect the science of psychology differs widely from that of psychiatry as it is applied in determining the mental status of industrial workers and of others. In the latter field the subjective methods that have been employed throughout the ages, the disadvantages of which led Binet to the construction of objective tests, are still in the ascendancy. It is per-

1 See "Research in the Selection of Motormen", by M. S. Viteles. *Journal of Personnel Research*, Vol. 4, pp. 173–99, August-September, 1925. See also "Research in Selection of Motormen in Milwaukee", by Sadie Myers Shellow. *Journal of Personnel Research*, Vol. 4, pp. 222–37, October, 1925.

2 "Test for Chauffeurs", by A. J. Snow. *Industrial Psychology*, Vol. 1, pp. 30–45, January, 1926.

3 "Tests for Taxi Drivers", by D. Wechsler. *Journal of Personnel Research*, Vol. 5, pp. 24–30, May-June, 1926.

haps true that there has recently been a somewhat belated recognition of the value of these psychological instruments on the part of the psychiatrist, but it appears to be a half-hearted acceptance that implies no true adherence to the ideal of complete objectivity in measurement toward which the competent psychologist is striving—as is the scientist in every other field. There is a difference in emphasis—with the psychologist, the emphasis is upon the perfecting of the tool as an objective instrument of measurement; with the psychiatrist merely upon its value as an aid in subjective diagnosis. This fundamental difference in point of view influences the contribution that each can make toward cutting off at the roots the causes of strife in industry. In so far as controlled conditions and objectivity in measurement represent desirable experimental conditions, the testing methods of psychology—subject to improvement as the individual tests may still be—may be said to possess inherent qualities necessary for the scientific consideration of human problems that involve the measurement of character in industry.

The inherent objectivity of the psychological approach in the measurement of character, as distinguished from the inherently subjective approach of the psychiatrist, is well illustrated in the attitude of the two groups toward the analysis of the so-called temperamental traits. Industriousness, ambition, application, and many other temperamental traits of the same kind must be analyzed in a complete evaluation of human personalities. It is true that there is yet no satisfactory method by which "the psychologist or any one else has been able to measure these traits".[1] Because they cannot now be measured is no reason for assuming, as is so consistently assumed in the psychiatric literature, that they can never be measured. In so far as these qualities may be even more essential for industrial life in many cases than are the qualities of competency, to the very same extent it becomes necessary that objective methods for their measurement be devised. The psychologist's continued absorption in the preparation of objective tests for the measurement of these traits is another expression of the faith that he places in objective instruments

[1] *The Psychological Versus the Psychiatric Method in Industry*, by E. L. Ray, M.D. MENTAL HYGIENE, Vol. 11, pp. 140–47, January, 1927.

and of his hope for a continually decreasing dependence upon subjective judgment, such as at present must be used in observing the temperamental traits. From the point of view of reliability and validity, tests of temperament to-day are comparable to our general intelligence tests of two decades ago. However, if progress in the development of these proceeds as in the case of general intelligence tests, the time may be not far distant when subjective methods for the analysis of temperament will be relegated to the same position of unimportance that subjective methods of judging intelligence occupy now.

This insistence upon objective tests for the measurement of character traits, whether they be mental abilities and defects or traits of temperament, does not imply that the psychologist depends exclusively upon the psychological tests for data concerning the make-up of an applicant for employment or of an employee. In an article on the clinical point of view in vocational selection,[1] I have insisted that "the competency of the applicant for a great many jobs in industry, perhaps even for a majority of them, cannot be observed from an objective score any more than the ability of a child to profit from one or another kind of educational treatment can be observed from such a score. There is no reason for suspecting that the capacity of an individual motorman to avoid accidents, or of a printer's apprentice to profit from instruction in this trade, can be expressed in an objective score, as easily interpreted by a minor clerk as by a trained psychologist, than for suspecting that the mental status of a child is revealed in the I.Q. which can be obtained by any teacher who owns a copy of Terman's Condensed Guide and a set of testing material. The one problem is as complicated as the other; the objective score in one case has in it as many elements of error as in the other, *and an adequate diagnosis in both involves interpretation by a trained psychologist based on observation of performance and a consideration of related data.*"

My own predilection with regard to the one who is to

1 "The Clinical Viewpoint in Vocational Selection", by M. S. Viteles. *Journal of Applied Psychology*, Vol. 9, pp. 131–38, June, 1925. See also my paper, "The Clinical Method in Industry". *Industrial Psychology*, Vol. 1, pp. 753–58, December, 1926.

administer this work is indicated in my use of the term "trained psychologist", as is the psychiatric preference in the use of the term "psychiatric method of study" by Ray [1] and Anderson[2] for a procedure which the psychologist has long used under the name of "the clinical method in psychology".

I also have no hesitation in agreeing with Anderson's criticism [2] of the psychologist who considers the psychological test as the sole or final selection agent, and with his statement that "the interview, if properly conducted and intelligently interpreted, opens up knowledge concerning the applicant's past history and ways of behaving that furnishes the most fruitful basis for judging what his future adjustments are likely to be".

It is in his idea of what constitutes a satisfactory interview and when it can be considered to have been properly conducted and intelligently interpreted that the objective slant of the psychologist is again revealed. He *measures* the effectiveness of the ordinary interview conducted by those who are responsible for selection in industry and finds, for example, that the agreement among 12 sales managers upon the fitness of 57 candidates for a sales position is about the same as would be obtained if the names of the 57 candidates were placed in a hat, shuffled, and drawn by a blindfolded man.[3]

In another study, a recent English investigation,[4] the psychologist has treated mass data on interviews, comparing judgments on traits made by psychologically trained and non-psychologically trained interviewers, and has established quantitatively the superiority of the trained interviewers over the untrained. And finally the psychologist formulates a program, such as that upon which B. V. Moore is at present engaged under the auspices of the Personnel Research Federation, for the objective and controlled study of diverse interview techniques and criteria. Starting with a point of view

[1] *Op. cit.*

[2] "A Psychiatric Guide for Employment", by V. V. Anderson, M.D. *Personnel Journal*, Vol. 6, pp. 417–41, April, 1928.

[3] See Poffenberger, *op. cit.*

[4] *A Study in Vocational Guidance*, by C. Burt *et al.* Industrial Fatigue Research Board Report No. 33. London: His Majesty's Stationery Office, 1928. 106 p.

similar to that of the psychiatrist as to the place of the clinical interview in promoting human adjustment, the psychologist in his attack on this problem shows a scientific attitude absent from the rationally evolved, instead of empirically demonstrated, formulæ of the psychiatrist.

The same difference in attitude is shown in the matter of the personal data obtained either in the application blank or during the interview. In psychological investigations in industry judgment on the significance of personal qualities such as age, marital status, education, and so forth, does not depend upon chance, but is based upon statistical studies of successful and unsuccessful workers. The results of such studies have been published by Goldsmith,[1] Manson,[2] Russell and Cope,[3] and others, and need not be discussed in detail here.

It is such objective treatment of mass data, however, that makes it possible to state, for example, with a known degree of reliability that cab drivers selected from men over twenty-five years of age are more likely to make good earning records than men under this age; that married men tend to earn more than single men; that from the point of view of earning, native-born Americans and Jews of any nativity are superior to other national groups; that a man with children has an advantage over a man without children; and so forth. It is such studies that make it possible to distinguish the successful electrical-substation operator from the unsuccessful on the basis of height, education, marital status, age, and the like, and to know with a determined degree of definiteness that weight, number of children, nationality, and certain other factors play but an insignificant rôle, if any, in determining success on this job.

Other types of investigation could be cited to demonstrate the objective character of the psychological approach as distinguished from the individualistic and subjective character of

1 "The Use of the Personal History Blank as a Salesmanship Test", by D. Goldsmith. *Journal of Applied Psychology*, Vol. 6, pp. 148–55, June, 1922.

2 "What Can the Application Blank Tell? Evaluation of Items in Personal History Records of Four Thousand Life Insurance Salesmen", by C. E. Manson. *Journal of Personnel Research*, Vol. 4, pp. 74–99, July, 1925.

3 "A Method of Rating the History and Achievements of Applicants," by W. Russell and G. V. Cope. *Published Personnel Studies*, Vol. 3, pp. 202–09, July, 1925.

the psychiatrist's methods. However, those already given are sufficient to demonstrate this difference between the two and to make it possible to pass on to a consideration of other characteristics that distinguish the psychologist's approach in industry from the psychiatrist's.

The technical developments of a science and its possible contributions are in large part influenced by what may be called its philosophical foundations. By philosophical foundations I mean the science's orientation toward its own content and toward other sciences. The importance of philosophical foundations is well illustrated in the history of science in general. So long as astronomy was limited by a belief in a universe created for men, with earth—inhabited by man—as its center, this science could not achieve the heights of discovery that have characterized it since that point of view was abandoned and imagination was projected into the space beyond earth. Chemistry enchained to a philosopher's stone remained alchemy. Anatomy and physiology in the hands of a church antagonistic to human dissection on religious and philosophical grounds could not uncover the essential facts upon which the later technical contributions of these sciences were based. Psychology conceived as a logical instead of an experimental system made but meagre contributions toward an analysis of the causes of human conduct.

Similar as are the aims of psychology and psychiatry, their differences in philosophical outlook are bound to be reflected in the character and effectiveness of the contribution of each. The differences in philosophical foundations are many. The most important of these is the psychologist's orientation toward the normal as contrasted with the psychiatrist's orientation toward the abnormal. At its very beginning, psychology set about to discover the laws that underlie the behavior of the average or normal human being. So concerned were psychologists with the average or normal that in early experiments by Wundt and others, results with subjects who showed extreme variation from the average were discarded as being of no value in formulating the general principles of human behavior. In the psychology of individual differences, starting with the work of Cattell in this country, the problem was oriented as one of differences within the

range of normality. That the feebleminded, for example, were not altogether neglected is well attested by the early work of Goddard and Binet and others, but individuals of this type were not and never have been the primary subjects of observation by the psychologist. The first important work on individual differences in this country, that of Cattell, had as its subjects a group of college students whose normality was beyond doubt. The work started by Witmer at the University of Pennsylvania in clinical psychology was directed toward aiding the adjustment of individuals well within the range of normality.

Much as he has tried, the psychiatrist seems never quite to get away from his experience with groups of seriously disordered individuals whom, in the early history of psychiatry, he was called upon to treat and who even to-day, in the case of many psychiatrists, constitute the bulk of his practice. It is true that a number of psychiatrists appreciate this situation and have taken steps to remedy the difficulty. Recognition of the problem is implied in the description of the mental-hygiene movement by its leaders as concerned "with not only the abnormal, but with the normal". In actual practice, however, there still persists an abnormal orientation, reflected, for example, in Jarrett's [1] statement as to the scope of mental hygiene in industry. "Mental hygiene would apply", says she, "to (1) a small, but potentially important group of mentally diseased employees; (2) a large group of individuals, possibly nearly half the working force, whose mental character is such as to require special consideration; (3) the largest group of workers, possibly a little over half, who have no appreciable mental difficulties and whose problem is chiefly to develop their mental ability".

A program envisaging nearly half the working force as in need of special mental-hygiene measures limits entirely too much the concept of normality. It throws a pall of abnormality over the activities of half the working force and by implication over half of the general population. This is widely removed from the psychologist's concept of the average human being as a normal being. It puts the burden of proving

1 *The Mental Hygiene of Industry*, by Mary C. Jarrett. MENTAL HYGIENE, Vol. 4, pp. 867–84, October, 1920.

themselves normal upon half of the population instead of assuming that he who conforms in his activities to the standards of the majority of the group is normal, whereas only those who vary extremely from the largest proportion of the workers and of the general population can be described as being in need of special consideration.

That "the study of mental and psychological abnormalities has given the psychiatrist a deeper comprehension of processes which take place in every individual—even in those regarded as unmistakably normal", as contended by Mayo,[1] seems questionable when examined from the point of view of everyday practice in psychiatry. The prevalent attitude of psychiatry and of the psychiatrist is perhaps better stated in the words of Stevens,[1] who writes: "If something *is* wrong with the mind in industry, to whom should industry turn for help if not to the psychiatrist, with his trouble-finding outfit of 'complexes', 'obsessions', and 'delusions'? "

Stevens has here chosen a happy phrase. It is in trouble-finding, whether it be in industry or elsewhere, that the psychiatrist seems most competent. It may even be said that he is inclined to look at human conduct through misshapen lenses, which distort the picture, bringing out the defects at the expense of the beauties—one might almost say the perfections—of human character. If the lenses, directed upon an individual, show nothing more serious, they reveal in him at least a perverted tendency to fall in love with his mother or to subordinate himself to his brother. Everything else that may be seen in the picture of the mental life of the individual seems blotted out by the psychiatrist's absorption in the abnormalities of conduct that he has observed in the psychopaths to whom his interest has until recently been largely confined.

On the other hand, the psychologist comes to industry with a common-sense orientation toward the normal, and as an observer trained in the interpretation of certain facts which are basic in any judgment that he may express. He comes

[1] See special number on "Psychiatry in Industry" of the *Monthly Bulletin* of the Massachusetts Society for Mental Hygiene, Vol. 6, pp. 1–6, February, 1926, with articles by Drs. V. V. Anderson, Elton Mayo, Augusta Scott, and H. W. Stevens.

prepared not to see primarily the abnormalities of human conduct, the Freudian obsessions, the irrational reveries, and so forth, but to study under controlled conditions normal human behavior and such deviations as may exist in well authenticated samplings, and as a result of such study, to arrive at principles of human conduct that will be applicable in the management of industry and in promoting the welfare of the human element in it.

INDUSTRIAL PSYCHIATRY *

HENRY B. ELKIND, M.D.

Medical Director, Massachusetts Society for Mental Hygiene

IN retrospect, one may recall that industrial medicine and industrial hygiene in this country are of relatively recent origin. Their history is probably not more than twenty or twenty-five years old. Their main interest in this country up to recent times has been in the field of toxicology, in the effects of industrial poisons upon the human body. They have also been interested in the problem of industrial fatigue, though chiefly on a physiological level, and in the effects of light and ventilation upon the health of workers.

Since the World War industrial medicine has developed considerably because of the more general introduction of workmen's compensation acts, which necessitated some form of medical practice in industry. As time went on, it became evident that the mere giving of first aid and treatment of accidents were not enough, and the full-time industrial physician was introduced, with his practice not limited to the treatment of accidents, but including the treatment of disease. This is particularly true of department stores, where accidents are relatively few.

There is no question but that industrial medicine and hygiene have demonstrated their worth to industry. At the same time, the industrial physician is quite aware that the orthodox materialistic approach to medical problems in the factory and in the department store is inadequate, and is beginning to feel that what is necessary is in addition a psychological or psychiatric approach to his problems. Almost every industrial physician with whom I have spoken is convinced of the need of this approach; a number have lamented their lack of psychiatric training. One or two who have had the good fortune to have some psychiatric training have acknowledged the advantage that this training has given them

* Excerpt from a lecture given in a course in "Psychiatry, Psychopathology, and Mental Hygiene" at Yale University, March 10, 1927.

and are quite positive that the psychiatric approach will do a great deal to improve the efficacy of medical practice in store and factory.

One of the great problems that workmen's compensation acts have brought with them is an increase in the incidence of compensation neuroses and malingering. To most industrialists there is either a justifiable claim for compensation or there is malingering; there is no middle ground. This view, so generally prevalent, is unfortunate. In addition to being untrue, it results in injustice to the injured worker and in increased costs to industry.

Now compensation neurosis is a mental disorder, with a psychology closely related to that of other well-known neuroses. Malingering, also, has a psychology of its own. The mental mechanisms involved are fairly well understood nowadays, and a knowledge of them may expedite treatment and, what is more important, assist in preventing them.

Certain facts in regard to these two conditions are of great practical importance. The first is that the degree of a compensation neurosis has no direct relationship to the severity of the injury. Another is that the symptoms of these two conditions depend mainly upon whether the patients find themselves in a situation in which they feel that they are personally responsible for the accident or whether some wealthy individual or company is responsible. There are, of course, other factors of importance. One is the fear of the future, when compensation will stop. "Will I not perhaps become ill again?" etc. Another is the attitude of certain physicians who, not understanding the mechanisms of either malingering or compensation neurosis, encourage these morbid processes. The activities of certain claim agents also promote the growth of these unfortunate conditions.

Of course, not all forms of neurosis following accidents are due to the element of compensation. They may be due to the injury itself, if that injury happens to have been one to the patient's head.

We often find the same mental mechanisms in cases of illness not following accidents when the question of compensation is a factor in the situation.

Industrial psychiatry not only considers compensation neurosis and malingering as important subjects, but is also interested in the other forms of mental disease and disorder which we find in the general population. As the mental disease and disorder discovered in industry are in general no different from the mental disease and disorder found in the general population, I shall not discuss this phase of psychiatry in industry.

Psychiatry can be of assistance, and has been, in the study and treatment of industrial poisoning, particularly where the majority of symptoms are on a psychological level. The most important symptoms of a number of industrial poisons are in the psychological sphere, and here psychiatry is often helpful in a differential diagnosis. Mercury, lead, carbon bisulphide, and a number of important industrial poisons have characteristic mental symptoms. If more industrial physicians were acquainted with psychiatry, I am of the opinion that a larger number of these cases would be detected than at the present time. There are many poisons, such as naphtha or benzine, whose symptomatology is not yet very well worked out, and which, in my opinion, would be better understood if studied from the psychiatric angle.

After this brief résumé of industrial psychiatry conceived as a specialty in the practice of industrial medicine, the remainder of my paper will be devoted to a discussion of that field of industrial management or personnel administration in which the psychiatric method has been found practicable or to which it may be applied with profit.

Industrial management or personnel administration is that phase of industrial or mercantile management which concerns itself mainly with the human factor and with the adjustment of the human factor. In this work one is not interested primarily in the pathological, but in the normal man or woman employed in business or industry. The adjustments that have to be made and that are being made day in and day out in every factory and store are beyond count. The opportunity, therefore, for the effective adjustment of worker to job is a tremendous one. We find the worker applying for work. What job is he interested in? What job does he apply for?

What work is available and of what type? Then there is the question of the employee's ability to do his work; the question of training; the question of the various vicissitudes and changes that come into one's life while working; the question of ambition, of promotion, of financial incentives, the desire for better wages, the need of earning more to satisfy one's needs and desires and those of one's family. Is a man's work satisfactory? Is he doing as well as he might? Is the job suitable? Is it healthy to work at? What is the attitude of the community toward it? The questions of discharge and transfer also come in.

To one who has worked in industry and has met these problems face to face, there is no need to be convinced of the magnitude of the problem. In industry a man or woman may be made or broken, and while industry occupies only a part of the workers' time, yet its influence upon their lives cannot be discounted. Unemployment brings about its strains and stresses; the business cycle has its unfortunate results; the growth and decline of industries, which at the present time take place rather quickly, have their effects upon the mental health of our working population; their families are necessarily affected. So, without describing in further detail the vicissitudes and difficulties of our industrial life, one can well see the importance of present-day industry and its influence upon the lives of our people. Anything that can be done in the way of a more effective adjustment of a worker to his environment is a contribution to the public health of the community.

In our time, in this country, the greater part of our population, when we include the families of workers, is connected in some way with industry, business, or commerce. Organized personnel work, industrial management, and so-called scientific management (as conceived in this country) until very recently have been based upon a mechanistic philosophy. Man is nothing more than a machine, to be treated according to engineering principles. Our engineering methods have been successful in the control of material things and forces and will, therefore, be successful in the control of our workers. Men like Taylor and those who followed him have approached

the problem of control of the human factor almost entirely from the point of view of an engineer. Attempts to be accurate were seriously made, extremely careful time and motion studies were organized, and elaborate job studies were devised. Extensive schemes and methods of an extreme mechanistic type were evolved which in this country have been called scientific management. Physiology and psychology were hardly considered at all and, when considered, were admitted to be essential only in theory, not in practice. The most effective critics of this school of so-called scientific management have been a small group of men in England working under the auspices of the Industrial Fatigue Research Board or of the National Institute of Industrial Psychology. These people have pointed out very clearly this lack of appreciation of physiology and psychology in scientific management, and, better than this, they have added to their criticism tangible methods based not only upon physics and engineering, but also upon physiology and psychology.

At the present time, American industry, as well as industry abroad, is gradually awakening to the importance of psychological and physiological factors in management. We see this in attempts at the selection of workers based on psychological tests. While many of these attempts have not proven satisfactory, a considerable number have demonstrated their practical worth. We find the General Electric Company at West Lynn particularly well advanced in this field, and there are other large corporations that are now employing psychological tests. This movement is not limited to the United States, for many other industrial countries, like Great Britain, Germany, Belgium, Japan, and Italy, are employing psychological methods in the selection of workers. In fact, across the water the matter has received so much attention that special institutes have been organized for the study and development of psychological methods in industry.

The psychiatric approach to other phases than selection has made very little progress. The group in England that I have just mentioned has made the greatest progress, though not a little has been made in some of the industrial centers of Continental Europe and Japan. In England some definite advances have been made in what is called vocational guid-

ance—that is, advising young men and women as to their future careers. This seems quite promising and the whole world is now looking upon this work with considerable interest and hope.

In this country psychiatry has had only a few opportunities to demonstrate its possibilities. The Metropolitan Life Insurance Company has employed a full-time psychiatrist for a number of years for its office force. What is perhaps the most auspicious and the best organized experiment at the present time is being carried on at R. H. Macy and Company, of New York City. Here Dr. V. V. Anderson, with a corps of assistants, is experimenting to determine where psychiatry and mental hygiene can be of the greatest practical assistance, and, when necessary, is developing special methods. The problem in department stores is in many ways different from that of factories, since the machine plays a relatively insignificant rôle in department stores as compared with factories. The main thing in department stores is salesmanship. Dr. Anderson's work concerns itself with the selection of employees, but what is probably the most valuable contribution of all is the guidance of employees during their employment period. Up to this time too much emphasis has been laid by some psychologists on the need of careful selection. "If workers could be picked out with even approximate accuracy by means of psychological tests, perhaps all the problems of maladjustment would be obviated; if once the worker were fitted to his job there would be no difficulties and labor turnover and absenteeism and many of the other wastes in industry and business which come from the frailties of the human factor would be brought to a minimum." This is a mistaken idea; no matter how carefully one may select by psychological tests, provision must be made for the guidance of workers in their working lives. Allowance must be made for changes within the worker and for the changes in working conditions that are constantly taking place. This, in my opinion, is the main contribution that Dr. Anderson is now making—namely, the insistence upon guidance throughout the working career instead of upon selection alone. Dr. Anderson's method differs from that of most industrial psychologists of the present day also in the fact that he does not place too much weight

upon the test score. No critical evaluation of the test score is made by some workers and there is little attempt to take into account other factors which must operate in a "total situation". The great value of the psychiatric approach over that of all other approaches is, in my opinion, that it is valuable not only for selection, but in the appreciation that it gives of the various adjustments and maladjustments that occur in every worker's life and the hope it offers of solution for some of them.

I may perhaps seem rather over-hopeful of the contributions that psychiatry has made and can make to industry and business. I should sound a restraining note and add that the benefits that psychiatry can give to the adjustment of the human factor in business and industry are limited; there are so many factors that human beings cannot change, and so many of the factors that operate significantly upon workers cannot be altered quickly even when known, and most of them are not yet even known. At present, however, there is every indication that psychiatry, psychology, and physiology have not reached the limits of successful application to business, and I hope, therefore, that the near future will see some of our young psychiatrists eager and anxious to go into industry, to learn of its background and of advances already made in the field of personnel work, and to adapt psychiatric methods to the needs of industry and business. To my mind, while the mental hygiene of the child is of exceedingly great importance and every effort should be made to do all that we can to bring about an adequate mental hygiene of the child, I wish to make a plea for the adult, for the parents who are in need of all the consideration that human science and art can offer. Whatever can be done to ease the lot of man in his adult life will certainly have a favorable effect upon his young.

I want to add one final point, and that is that the psychiatrist who approaches industrial problems must adapt himself to the conditions that he finds in industry. He must adopt a new terminology; he must adopt a new point of view whose essential interest is in the normal rather than in the abnormal. He must acquaint himself with other arts and sciences than psychiatry and psychology; he must not only have a keen appreciation of psychometrics and of psychiatric examination

and medical practice, but he must know something of the industrial environment in terms of ventilation and illumination; he must know something about industrial poisons; he must know something of such methods in industry as are involved in mechanical processes of manufacturing; he must know and understand systems of wage payment; he must understand the philosophy and methods of workmen's compensation and the various benefit plans; he must have a thorough knowledge of the large number of welfare activities now going on in industry; he must be something of a sociologist. The main point is that, to be successful, he must know Industry as well as Man.

The three cases that follow will give some idea of the situations that an industrial psychiatrist is called upon to meet:

Case I.—Psychoneurosis: neurasthenic type (?) compensation neurosis.[1]

Mrs. Anna T., factory worker, married, aged thirty-six, had been out ill and drawing benefit money for a number of months. The doctor in charge of the benefit office had examined her and could find no cause for her being away from work so long. For this reason she was referred to a psychiatrist for examination and study.

The family history was negative for psychopathic trends. The patient was married and her husband was living. He was a common laborer and had not been employed for about four months. There were three children, aged sixteen, twelve, and nine. The oldest worked in a factory and earned $9 weekly. The home was located in a poor neighborhood. The patient herself was poorly, but neatly dressed.

The patient was born in Italy. She was not able to give any information about her birth or early development. (She spoke poor English.) She had had measles and mumps when a child. There had been no serious illnesses until four years before when she had begun to complain of stomach trouble, which was probably caused by appendicitis. Appendectomy had been performed about three years before. Menstruation

[1] Quoted from the *Journal of Industrial Hygiene*, Vol. 8, pp. 99–101, March, 1926.

had been scanty for a number of years, but regular. There was considerable leucorrhea, but very little pain.

The patient had never gone to school and could not read or write either Italian or English. She had a fair knowledge of English, though she spoke it brokenly, and at times it was difficult for her to understand the examiner.

There was a very slight, but habitual use of wine, but no hard liquors were used. There was no excessive use of coffee or tea. No sexual perversions were made out. The patient complained, however, that her husband was excessive in his demands. She said that she reacted coldly to sexual relations, yet she stated also that her husband was affectionate and treated her well. She was not jealous of him nor did she suspect any infidelity on his part. She said that she liked him. He was a man of good habits and had never been intoxicated.

The patient was of slight build, appeared somewhat anæmic, and seemed to have lost weight. Her present illness had begun about four years before, the symptoms mainly complained of being gastric in type. She had continued to work in spite of her illness, but had found it necessary to give up about five months before. She was at the time receiving $12 a week from the factory benefit plan, while her normal wages for some time had ranged from $16 to $19. She would, however, probably have been receiving less at the time of examination, owing to a general decrease in wages due to a recent business depression. (There was a question whether or not the family was receiving aid from the overseers of the poor of the town in which they live.)

The patient complained of general aches and pains, gastric distress, and eructations of gas. She had no headaches and had never vomited. Two months before she had had a short period of nausea. Her bowels were moving daily with the aid of cathartics, but previously they had been functioning poorly. During the past few months she had been an out-patient of two excellent general hospitals, both of which had made the diagnosis of no physical disease except ptosis of the stomach. She had been advised by both to wear surgical corsets, and stated that there was some improvement since she had been wearing them. She had remained home the greater part of the time, staying in bed, with little or no sleep at night. On

account of her father's death two months ago, she had not gone to amusements of any sort. Her home interests seemed narrow. Although she avowed her desire to return to work, she strongly resented the suggestion that she was able to work.

She was quiet and coöperative during the examination, but because of language difficulty, it was almost impossible to get a clear picture of the content of her thoughts. Her mood seemed normal, though there seemed also to be an unconscious attempt to simulate distress. No examination of her intellectual functions was made. Whether or not she had insight into her condition it was difficult to say. No delusions nor hallucinations were made out.

Physically, the patient was poorly developed and nourished. Her pupils were negative, her teeth in fairly good condition. There was, however, some foulness of the breath. Her tonsils were not seen. Her heart was negative except for a faint murmur heard only at the apex, probably functional. Her abdomen was flabby and striated. There was an abdominal scar in the right lower quadrant due to a McBurney's incision. No gynecologic examination was made. (Gastro-enteroptosis was probable.) The physical examination was otherwise negative.

It appeared to the examiner that this patient was an inferior person, both as to physical development and as to mental equipment. She seemed to exaggerate her symptoms, which were apparently residuals of an appendectomy that were being utilized as a means of resolving difficult situations in her life. It seemed, however, that the process in the main was based on a desire to continue her invalidism in order to secure without working compensation that was very near in amount to the wages that she would have received if working. This process had been helped along by out-patient physicians who had told the patient that she was seriously ill, that she should rest a good deal and even stay in bed. No wonder that her muscles became atonic after a while and that any effort to work caused early fatigue. Therapy was advised on these premises.

The patient was told that her benefit payments would be continued without any reduction. She was also advised to

work as long as she felt able to and told that she would be paid at a maximum rate for whatever she made. She was told to try to get up to four hours daily as quickly as possible. The psychogenetic character of her symptoms was explained to her as well as was possible under the circumstances. She was told not to go to bed during the day, and was advised to eat almost anything she craved and to forget all dietary systems previously prescribed for her. Moving-pictures or some other form of amusement were also suggested as a means of helping her back to economic efficiency. An iron tonic in pill form was prescribed. She promised to start work the next day. Meanwhile the department superintendent was apprised of the plan and consented to coöperate.

It was about a week before this patient could make up her mind to fall in with this plan. At the end of the week she was working four hours daily and beginning to like it. A new, but relatively easy job had been picked out for her, but after a few days she objected and wanted her old job back again, though it was in fact a little more difficult than the job to which she had been first assigned. After two weeks or so she seemed much better both physically and mentally. She seemed stimulated by the relatively high wages she was receiving.

A shutdown of the whole plant interrupted this plan for about a month. When the factory reopened, however, she was ready for work. After a week or so she began to work more than four hours daily. This was allowed to go on for a while. Then she was told that she had proved she could work, and that her benefit payments would be stopped, but that she would be guaranteed full time and maximum wages. She consented to this plan—how readily it was difficult to ascertain—and is now working eight hours practically every day and hardly ever complains of illness.

This case illustrates a common occurrence in accident or sickness insurance practice, especially when operated under factory or mercantile auspices. The coddling by non-industrial physicians who are not trained in psychiatric methods is an important factor. Another factor, of course, is the relative ease with which one can prolong convalescence and receive during this period financial aid almost equal to what

one could earn if working under usual conditions. The treatment followed in this case is suggestive of what might be tried profitably in similar cases. It also gives hints for prevention. It seems, too, that some method of benefit payments should be devised which would pay premiums to workers for returning to their jobs when physically and mentally able instead of paying them premiums for remaining away until the last possible moment, as is now rather commonly done.

Case II.—Paranoid reaction.[1]

A young woman of nineteen, of bright appearance, was referred to me as being dissatisfied with her work and desiring a change of job—a desire that could not be satisfied at that time. Leaving the organization was the next step, and she was sent to me for solution of her problem. She had been employed for six months in the auditing office of a department store, her job consisting of checking and filing duplicate sales slips. After some time she noticed that she was not being treated fairly by her forelady, that she was being "picked on" and reprimanded without cause. This made her nervous and somewhat dissatisfied, as she believed that she was doing her work as well as the majority. Some time later she began to feel that her fellow workers also were not treating her as they should, that they were conspiring to injure her with a view to causing her to lose her job. She stated that she was becoming more nervous and dissatisfied. Questioning brought out the fact that her widowed mother had been ill for several months; that she was the family's only means of support; that a sister, aged twenty-one, who was able to work, had been unable to find a job; and that she herself would not take any work in the store but an office position. She felt that work as a stock girl would be a demotion and considered it a sort of disgrace. (This form of class prejudice is quite common and is not peculiar to this girl.)

It did not take very long to see what was the prime demoralizing factor in this girl's case. She was suffering from congenital left internal strabismus, which certainly made it difficult for her to use her eyes for fine reading. Her difficulties were interpreted to her in the following conversation:

[1] Quoted from the *Journal of Industrial Hygiene*, Vol. 6, pp. 119–21, July, 1924.

"You have had to use your defective vision in a job where good eyesight is essential. The light is not always good where you are working, and very often it is hard to decipher what is written on duplicate sales slips. This has made it difficult for you to do your work. Your forelady has tried to help you, but you could not see that this was necessary. You were trying very hard to do your best. You are naturally bright and you could not see why you could not do your work efficiently. This made you nervous and you lost your balance about what was happening around you. You unjustly began to suspect your forelady of being too severe with you and, what is more unusual, to suspect your fellow workers of treating you unfairly and of conspiring against you. In my opinion these suspicions were due to a nervous state of mind and were aggravated by the fact that you knew you had to work. Your sister could not obtain a position and you could not think for a moment of giving up this job which was so unpleasant to you. You would not take another position in this store, where you would not have to use your eyes, for you felt that it was a disgraceful thing to do. I do not say that you thought all these things out as I have mentioned them to you, but this is how I believe you came to feel as you do. Now you must recognize the fact that you have a physical defect, your defective vision, and that it cannot be remedied. You have told me that your own doctor, who is an eye specialist, told you this. The proper thing for you to do is to accept a position which you can fill efficiently and satisfactorily, which is available, and which will not put any strain on your eyes, and this is a position as stock girl. You must try to live down your prejudice against it, for you are unreasonable to feel the way you do about it. The truth of the matter is that a stock girl's job is nothing but an apprenticeship to a sales position. In department stores, where you like to work, sales people receive the better salaries and there are opportunities for promotion to assistant buyer or buyer. The salary possibilities are much greater in the case of sales people than in the case of office people."

As a result of this conversation, the girl accepted a position as stock girl. After a few weeks, the superintendent stated that she was doing excellent work. A week or so later

it was reported that she had some paranoid ideas about me. She felt that I was trying to make her lose her job. She was interviewed again and the reasons for her transfer were explained in detail. She stated that she had not fully reconciled herself to being a stock girl. This was gone into at length, and she was told that the superintendent felt very much pleased with her work. This interview, with the encouragement offered, seemed to brighten up the girl's countenance, and she went away promising to leave her prejudices in the matter behind her. The reports about her work and about her attitude following this interview were excellent. A month later she temporarily left the store for an operation on her eye, and at the present time she is anxiously waiting to regain her strength to go back, not as a clerical worker, but as a stock girl. Furthermore, she has seen to it that her sister is working for the same company.

This case illustrates how an application of the principles of mental hygiene can bring about a more efficient adjustment of the employee to his job and make for salvage and for a cutting down of labor turnover. There is one less in the army of the dissatisfied. Another possibility has been avoided. This girl might, in a short time, have developed a true psychosis. Let us suppose that she had been allowed to leave the organization and that she had applied for work at another department store. She undoubtedly would have applied for clerical work again. The same train of symptoms would have followed with exaggeration. Let us imagine that this cycle of events occurred several times. It is probable that mental disease would have been the result. A paranoid personality, paranoia, or dementia praecox paranoid may be conceived as possible end results.

Case III.—Anxiety neurosis.[1]

Mrs. R. B., a comptometer operator, aged twenty-two years, was referred to the health department because of headaches which were interfering seriously with her work. Up to the time she was examined by a psychiatrist, she had been frequenting the health department on an average of three times a week for tablets to relieve her headaches. About a year be-

1 Quoted from the *Journal of Industrial Hygiene*, Vol. 6, pp. 254–55, October, 1924.

fore she had been referred to an excellent general hospital, which diagnosed her condition as migraine. She received no benefit and her headaches grew worse. To summarize the case, the important facts were as follows: Her headaches, frontal in type, began at the age of twelve. She never experienced any of the typical migraine figures and very rarely suffered nausea. Three years before, she had been married, but had separated from her husband two or three months later, after which her headaches had become worse. She and her husband were both Catholics and divorce was practically out of the question. She would have liked very much to live with her husband if he had been a different kind of man.

It seemed that her headaches began in the following way: Her mother suffered considerably from headaches and received a great deal of sympathy from a large family and from her husband (the father) when suffering from one. Our patient admitted that she imitated this tendency in her mother in order to receive sympathy herself, and that she was the pet of the family and received considerable sympathy from them. She recognized the same tendency to this conduct when she was in the store, especially when thoughts of her husband and of her difficulties with him came to mind.

She was in excellent bodily health, as disclosed by physical examination. She wore glasses because of astigmatism and apparently obtained relief from them. She was advised to be examined again by an oculist to see if her glasses were correcting the defect sufficiently. It was explained to her that the headache was chiefly psychogenic in character, but was centered about a slight organic condition which involved her eyes. (Peri-organic symptoms are very common in functional nervous diseases.) Following this simple form of psychotherapy, the patient reported at the end of six weeks that she had had only one severe headache and two "light pressures" on her head, and that she felt very much better and happier. (Her glasses were not changed.)

This case illustrates how an individual who was on the point of being discharged because of frequent absences due to headaches was reclaimed and made efficient in her work. This adjustment, of course, resulted in her becoming again satisfactory to the management.

ABSTRACTS

SCIENCE AND LEGAL PROCEDURE. By Roscoe Pound. *The American Journal of Psychiatry,* Vol. 8, pp. 33–51, July, 1928.

Doctor Pound discusses here some of the causes of the present unsatisfactory relationship between psychiatry and the criminal law. His intention is not to suggest remedies—he states frankly at the outset his lack of confidence in quick and easy solutions, such as the enactment of new legislation—but to analyze the underlying factors in the present situation, in the belief that the legal doctrines and practices with which the psychiatrist comes into contact can be effectively criticized only on the basis of a thorough understanding of the conditions that gave rise to them.

The great problem of the law is that of maintaining a due balance between the need of stability, upon which the general security depends, and the need for adjusting to new conditions and individual situations. Throughout legal history, the emphasis has fluctuated between these two points of view, some eras insisting upon rigid rules and fixed procedures, others giving the widest possible latitude to judicial and magisterial discretion. The problem is especially acute in the case of the criminal law, with its possibilities of abuse for political or class ends. Fear of such abuse is at the bottom of many of the checks and balances and limitations and mitigating devices that so often make prosecution in the modern American city feeble or futile. Yet general as is the dissatisfaction with this state of affairs, any attempt to change it by allowing more margin to official discretion meets with instinctive opposition.

The necessity for considering the general security makes it impossible for the law to experiment with new theories and methods, as is done in other fields. New forms of treatment in medicine or surgery or psychiatry, for example, can be tried out by any practitioner, acting upon his individual judgment. But in the interests of certainty, uniformity, and equality, the law must be general in its applications. A judicial decision involving a new situation applies not only to the particular situation in question, but, as a precedent, to future situations of the same kind. It is obvious, therefore, that freedom of experimentation in legal procedures would result in an intolerable state of affairs.

Another point not to be overlooked in any consideration of legal reforms is the importance of the public belief that the legal machinery

is achieving justice—a belief that is hardly less important than the actual achieving of justice. If our system of criminal law is to be remodeled in accordance with modern scientific conceptions, the public must first be brought to understand and accept those conceptions; otherwise the reforms are likely to provoke a reaction that will leave our last estate worse than our first. Such a reaction is in progress now in the field of penal treatment, where the reforms instituted as a result of scientific study during the progressive era at the beginning of the century are now being threatened because they were put into effect before the public had had a chance to grasp their meaning or to readjust preconceived ideas as to prisoners and their treatment.

Taking up the question of the attitude of the law, and especially the criminal law, in cases involving mental disease, Doctor Pound goes back to the historical environment in which our present doctrines and practices took shape. Criminal law goes back to the days when the whole community turned out to avenge the commission of a crime. The law developed as a regulation of this public vengeance into a sort of orderly lynch law, and then into a delegation of its execution to officials and tribunals representing the public. This crude revenge theory of crime was predominant until the nineteenth century, when, in accordance with the philosophical thought of that period, it was replaced by a theory of retribution and the vicious will. Crime was now regarded "as a wilful departure from the standards of right and wrong promulgated by the law", and the criminal as one who, having the ability to discriminate between right and wrong and the power to choose between them, deliberately chose to do wrong. Lately this whole system of will jurisprudence has been breaking down. Emphasis is being placed more and more upon conduct that endangers the general security, and there is growing recognition of the fact that the "cheerful idiot" is often more dangerous than the individual who is intentionally vicious. But our criminal law was shaped under the influence of the will theory, and the conception of a crime as made up of act and intent is still the orthodox conception.

The legal theory of the relation between responsibility and mental disease is a direct outgrowth of this conception. If a crime is made up of act and intent, then, logically, mental disease might affect either the act or the intent. In the working out of this theory, England and America differed, largely due to a difference in practical situation. England was already entering upon the urban, industrial stage of social development, which compelled practical, even though unavowed, recognition of the primary importance of the concept of the general security rather than that of the vicious will. The

English courts, therefore, did not try to be logical. They stopped with a consideration of the intent element, and having formulated their doctrine in terms of the will theory with reference to that element, they fitted it roughly to the needs of the general security by means of the charge of the court, which gives it a practical application to the facts of the particular case. Many American courts, however, carried the idea out to its logical conclusion, and considered the effect of mental disease upon the act element, thus adding to the English doctrine a further doctrine of the irresistible impulse.

This development was in accord with the demands of public opinion in America, where conditions were still in a more or less primitive, pioneer stage. As in all such communities, great stress was placed upon family honor, and there was a deep-seated feeling that it was not only a man's right, but his duty, to resent insults to the women of his household and interference with his domestic relations, even to the point of killing. Most of the killings that attracted public attention during the last century were of this nature. The inherited criminal law, which made no provision for this situation, was adapted to the demands of public sentiment through the power of juries to render general verdicts and through a straining of the doctrines as to insanity.

To-day we are dealing with an entirely different set of conditions. Frontier ideas of honor are largely obsolete, new types of killing are attracting attention, and the public is demanding the conviction of killers as emphatically as it once demanded the acquittal of the avengers of family honor. And in the effort to meet this new state of affairs with doctrines and practices shaped by the demands of the past, we are, characteristically, resorting to a patchwork of remedies.

One of the unfortunate results of this use of the insanity law to get around the law of homicide in certain cases was its effect upon expert testimony, especially the tendency to place the expert in the position of an advocate rather than a witness. "To some degree this is an outcome of our controversial mode of getting at the facts. Hence to some extent it exists in England to-day. . . . But it has gone to great lengths in America largely because in the homicide cases in which insanity was used as a means of plowing round unpopular demands of the letter of the law, experts were in substance and were expected to be advocates. It was their job to work out and expound ingenious theories to make out an insanity for legal purposes and for that one trial, where every one understood that for other purposes and for other occasions the man was undeniably sane."

Among the other factors that played a part in shaping our forensic practices was the use that our pioneer communities made of the courts

as places of entertainment. With practically no other source of diversion open to them, the entire adult male population would crowd into the courtroom, to follow with the appreciation of connoisseurs the fine points in the game of justice. This demand of the public for a battle of wits tended toward an over-development of legal procedure, which was further encouraged by the fact that these pioneer communities attracted many debtors and others whose interests were best served by a technical procedure that offered as many opportunities as possible for delay and legal juggling.

Later, in the era of railroad development, leadership in the profession passed to the professional representative of the public utility, and he, again, found that his advantage lay in an over-development of legal procedure. His effort was to steer the case away from the jury, whose prejudices he had cause to fear, while his correlative, the professional plaintiff's lawyer, fought for a jury trial. "This struggle led to legislation and minute judicial decision on every detail of procedure, as a result of which it became a settled American dogma that the trial judge was to be no more than an umpire in the game between counsel. Expert evidence had to be fitted into this game, and, as with every other feature of the game, was fitted in by a system of artificial rules, logically developed for their own sake and for the sake of the game."

To-day, with automobiles, movies, radios to satisfy the public's need of diversion, the court's function as a public spectacle has ceased, except in certain sensational cases which yellow journalism plays up. The demand now is that judicial business shall be dispatched with the swiftness and efficiency befitting an age that has taken the factory for its model. And just at the time when the best thought and influence in the legal profession are needed for a thorough overhauling of forensic practices, the interest of the leaders of the bar has almost entirely moved away from the courts. Their aim now is to steer their clients away from legal difficulties and keep them out of the courts.

This attitude of the profession is reflected in our law schools, where the criminal law is neglected because neither teachers nor students are interested in it. The great teachers of law have turned to other branches, and the students seek no more than that minimum of knowledge of the criminal law which is required of every student. They are interested in the subjects with which they expect to be concerned in their professional lives, and no young man of any ambition in a national law school to-day is preparing for a practice in criminal law.

Another factor that has tended to debase the criminal law is its close connection with politics. This difficulty is met with everywhere and in every age, but it is exaggerated in this country, where we have

put the whole machinery of enforcing and applying the law into politics. Since reëlection and political advancement depend upon keeping before the public, both judge and district attorney are often less concerned with carrying on efficiently the everyday work of prosecution than they are with its more sensational aspects, which may win them a place in the newspaper headlines. This state of affairs is not conducive to the development of the type of magistrate needed in our cities to-day.

These are the conditions under which the criminal law is called upon to deal with the problems of a new social and economic order and to cope with complex scientific questions which are not only beyond the grasp of a jury's common sense, but which science itself often cannot answer except with qualifications and reservations. At the same time, new burdens are being piled upon the law through the breakdown of the authority of church and home; the orthodox analysis of crime into act and intent, which is the foundation of our substantive law, has been discredited, and no assured basis has yet been found to take its place; and an urgent demand is being made for individualization in the application of legal precepts and penal treatment.

These are not problems that can be solved overnight, nor can their solution be achieved by any one man or group of men. "One-man research in law will no longer suffice. . . . it must be done coöperatively by scholars of many types and in many subjects, uniting their learning, their organized experience, and their trained energies in a joint effort. It must be carried on for its own sake in a purely scientific spirit. It must not be done upon single controversies as they arise, but upon the whole field in and out of which controversies arise. It must involve long, patient, and self-sacrificing labor on the part of scholars who are not hurried by a demand that they 'show results' day after to-morrow, or fill out the measure of an annual report at regular intervals. They must be in a position to devote to each problem all the time and labor and thought which scientific method may require."

Doctor Pound himself feels that this work can best be carried on in connection with our universities, which not only are assured of public confidence, but offer the conditions requisite for an effective quest for truth. As an example of what is being set on foot in this line, he cites the program of the Institute of Criminal Law, at Harvard University:

"As director there is to be a research professor giving his whole time to the institute. He will have no teaching obligations, but may, if he chooses, conduct one graduate seminar as a means of trying out his ideas. With him are to be associated the two teachers of

criminal law in the regular curriculum, each relieved for this purpose of one-third of his teaching work. With them will be associated also two experts, giving their whole time to the institute, one as professor of penal legislation and administration, the other as professor of criminology. To this staff we shall add a group of research fellows, some of them candidates for a degree, some of them invited specially to do work of research in criminal law for its own sake. Above all we shall seek to enlist in this institute the interest and coöperation of members of other faculties of the university working in related fields. We shall seek to make connections with the medical faculty—with psychiatrists and neurologists. We shall seek to make connections with the faculty of arts and sciences—with psychologists, and economists, and sociologists, and experts on government, and experts in social work. I hope to see such work organized presently and going on in all the great law schools of the land."

DRUG ADDICTION: A STUDY OF SOME MEDICAL CASES. By Lawrence Kolb, M.D. *Archives of Neurology and Psychiatry,* 20:171–83, July, 1928.

In former articles, Doctor Kolb has dealt chiefly with what he terms the dissipated type of drug addict—that is, the type that becomes addicted because of the pleasure derived from the effects of the drug. The present paper is concerned with a group of patients from a much smaller class—those whose addiction is the result of medication, either prescribed by a physician or self-administered.

With the idea of determining the special characteristics of this type of patient, 119 cases were studied, 74 of them men and 45 women, 113 white and 6 colored. In 115 cases the drug of addiction was morphine; in one, heroin; in two, opium; and in one, paregoric. The interesting point here is the great preponderance of morphine over heroin addicts. According to information supplied by the Narcotic Division of the Bureau of Internal Revenue, the relative prevalence of the two types of addicts in this country would seem to be one case of heroin to every eight of ten of morphine. The very much lower rate of heroin addiction in the group of medical cases Doctor Kolb attributes largely to the fact that heroin, as it is used therapeutically, is less likely to cause addiction than morphine, chiefly because the dose is much smaller.

Seventy of the 119 had become addicts through medication by physicians and 49 through self-medication. Of the latter, 18 had received their first doses from a physician and then had continued to buy the drug without his knowledge until they became addicts. This naturally happened much more frequently before the Harrison Law

went into effect in March, 1915. This law made it illegal to sell narcotics to unlicensed persons except on prescription and forbade the refilling of prescriptions containing narcotics. Of the 41 persons in the study group who became addicts after March, 1915, only 11 were in the self-medication class, and seven of these 11 appeared from the evidence to be of the dissipation type of addict rather than the medical, though they persisted in attributing their addiction to medication.

The ages of the study group, at the time of examination, ranged from twenty-eight to eighty-one, the average being 45.7 years. The ages at which addiction began ranged from fourteen to sixty-six, with the average at 29.33. A comparison on this point between those who became addicted before the Harrison Law went into effect and those whose addiction began after that date showed a noticeable difference between the two. For the former the ages of addiction ranged from fourteen to sixty-four, with the average at 28.09 years, while the age range of the latter was twenty to sixty-one, with the average at 32.9 years. A similar difference was noted in another group of addicts, which included dissipators as well as medical cases. This would seem to indicate that the average age at which addiction begins has risen about four years since the Harrison Law became effective.

Most of the 119 addicts still had the condition for which opium had been originally taken, or showed some residual of it. With the exception of the seven cases already mentioned, there was no reason to doubt that the cause of the addiction was as alleged. But while the introduction to opium may have been due to a physical disease, in most instances this condition probably had less to do with the actual addiction than other factors, such as carelessness in the use of the drug or ignorance of its effects or nervous instability. This last was an important causative factor. In a study of another group made up of unselected addicts, Doctor Kolb found that 86 per cent had had an abnormal nervous make-up before they became addicted. In the present group, 80, or 67.2 per cent, had been definitely neurotic or psychopathic before addiction. Using opium originally to relieve physical distress, they had continued to use it because of the relief it gave from feelings of inadequacy and inferiority and the restlessness of unsatisfied cravings.

Of the 74 men in the group, 33 had been heavy drinkers either before addiction or between cures and relapses. Twenty-five of the 33 had been definite drunkards. Only one of the 33 continued to drink after he became addicted to morphine, and then his drinking was moderate. But all of them resumed drinking during periods of abstention from the drug after a cure. In most of these cases both

the drinking and the addiction were due to an underlying nervous instability.

In this connection a question arises as to the effect of prohibition upon drug addiction. For light on this point, a careful investigation was made of each of these medical cases as well as of numerous cases of the dissipator type. The evidence was clear that while whisky is still easy to obtain, the increasing strictness of the narcotic regulations during the last ten years has made it more and more difficult for addicts to get narcotics either legally from physicians or illegally from peddlers. Five of the drunkards in the group under study did become addicted to narcotics after prohibition went into effect, but in no case because of inability to get whisky.

Heredity in the form of nervous difficulties in blood relatives was studied in 118 of the addicts and was found to be tainted in 69 cases and normal in 49. As in practically all studies of nervous heredity, the information on this point was in all likelihood incomplete. Complete information would undoubtedly have increased the proportion with a nervous taint. The conditions that were considered to indicate a nervous heredity were organic nervous diseases, psychoses, definite functional neuroses, epilepsy, psychopathic personality, and a strong family tendency to migraine, asthma, or alcoholism. Drug addiction was not included, as it was considered inadvisable to enter upon a study of such addiction with the assumption that it indicated nervous instability. One or more additional addicts, however, were found in nine of the families studied. To give an idea of the heredity of the group, 22 cases of psychosis and two more probable cases were found in the families of 16 of the addicts, and one probable case in another family. A case of epilepsy occurred in each of seven other families and a case of fits of undetermined nature in still another. Drunkenness was found in the heredity of 33 of the addicts, but in only 10 was it the most important factor in the defective heredity. Of the 25 drunkards among the addicts, five had no drunkenness in their antecedents and two had a normal heredity.

An investigation of the industrial efficiency of the group showed that 90 had good or fair industrial records, working regularly and satisfactorily, while 29 had poor records, working irregularly or with long periods of idleness. The poor records were due chiefly to drunkenness preceding addiction, physical diseases, or nervous instability combined with attempts to cure this addiction. In studying the effects of opium on the efficiency of addicts, it is always difficult to separate the effect of the drug from the effects of the disease for which it was taken and of the psychopathic traits that lie back of the addiction. Some neurotic persons who work well without opium are lulled

by it into a state of indifference and idleness, but on the other hand inadequate, shrinking personalities are sometimes relieved of their sense of inferiority by opium so that they are able to face the world more efficiently, and pathologically restless persons may be just sufficiently soothed and stabilized by it to be able to work regularly and steadily. Drunkards are especially likely to benefit in their social relations as a result of addiction. They get the same effect from opium as from whisky without being made vicious or disorderly. Judged by output of work and by their own statements, none of the nervously normal addicts in the present group were less efficient as a result of opium, but if observations could have been made upon them several years before and several years after addiction, it is probable that some listlessness and let-up of effort would have been apparent after addiction.

Seventy-nine of the 119 in the group were married or widowed, 15 were single, and 25 separated or divorced. Eighteen of these last were among those classified as having an unstable nervous constitution, and this instability rather than the addiction seemed at the root of the marital difficulties.

Ninety of the group had never been arrested. The remaining 29 had been arrested a total of 98 times. Twelve of these arrests were for violations of the narcotic laws. Eighty-six were for other offenses, 71 of them arrests of drunkards and 61 of drunkards who were not addicts at the time of arrest, but were drunk. The one robber was a former drunkard who had been convicted of robbery before he became addicted to opium. Sixty-two of the 86 arrests were for drunkenness or conduct while drunk. "It seems clear", Doctor Kolb comments, "that the inadequate persons who seek relief by excessive indulgence in intoxicants or narcotics are much more serious problems as drunkards than as addicts. In fact, some of the drunkards became orderly, law-abiding citizens after they abandoned whisky for opium."

Twenty-six of the 119 patients had never taken treatment, although some of them had made unsuccessful attempts to cure themselves of the habit by gradual reductions of the dose. The remaining 93 had been treated a total of 320 times. Doctor Kolb considered the condition of 40 of the 119 curable and 13 of them have since been cured. In 10 cases, the advisability of administering treatment was questionable and in 69 treatment was considered contraindicated. Several factors enter into this question of the advisability of attempting to cure addicts. From the medical standpoint, the physical and mental well-being of the patient is the only consideration, but the social handicaps under which the drug addict labors are so heavy that their possible effects upon his general welfare cannot be disregarded. The

suspicion and condemnation with which addicts are regarded by the public, including many physicians, the difficulty that they find in securing employment, and their constant dread that the time may come when they will not be able to secure supplies of the drug regularly—all are arguments for attempting cure. In Doctor Kolb's opinion, treatment is indicated in the case of every addict who could live comfortably without narcotics after periods of abstinence ranging as high as six months. In general, treatment is contraindicated in cases of long-standing addiction combined with physical diseases that give pain or discomfort, and in certain cases of old people who would suffer as a result of the withdrawal.

A comparison of these medical addicts with the group of pure dissipators shows certain differences and certain similarities. All the dissipators owe their addition to abnormal impulses and the accident of association, while 32.8 per cent of this group are normal and owe their dissipation to the accident of disease. The remaining 67.2 per cent are unlike the dissipators in that their introduction to opium was due to disease, but are like the dissipators in that the actual addiction, or its continuation, was the result not of disease, but of an abnormal susceptibility to the soothing effects of opiates. While inebriates are common in both groups, other types of psychopathic persons are more common among the dissipators. Neurotic, asthmatic, and migrainous conditions are more common among the medical cases.

BOOK REVIEWS

AN INTRODUCTION TO SOCIOLOGY. By Ernest R. Groves. New York: Longmans, Green, and Company, 1928. 568 p.

It is not usual for a psychiatrist to undertake to review a textbook in sociology. Yet the modern student of human conduct scarcely knows where to draw the line between the respective fields of sociology, psychology, and psychiatry. We hear a great deal about various schools of social thought. Pitirim Sorokin gives an excellent review of them in his *Contemporary Sociological Theories.* These schools of social thought seem to classify themselves according to the variables that influence social phenomena. Thus, the mechanistic school regards social phenomena as resulting from physical and mechanical forces, while the geographical school explains them by geographical causes, such as climate, land topography, and so forth. The biological school gives as variables race, selection, and heredity; the bio-social school, population density; the bio-psychological school, the instincts. The psychological school sees social relationships as secondary to psychic phenomena; the sociological school considers "mind" as determined by social forces; and the psycho-sociological school's variables are certain psycho-social phenomena, as religion, law, and so forth. These are all essentially dualistic conceptions.

Sorokin leaves no doubt as to which is the cart and which is the horse. But to-day we might say that even the logical order of horse before cart is a bit of an anachronism. Is not the horse (motor) rather part and parcel of the cart (automobile) in this present day and age? Certainly in the field of human conduct the "mind" is as much a product of social relationships as the latter are determined by the human "mind". Even such purely psychic factors as some of the instincts have their social determinants, at least phylogenetically, and the day may come when such purely environmental phenomena as climate will be modified by human activity. So the psychiatrist and the psychologist are at sea without some understanding of social phenomena, as is the sociologist without a knowledge of psychic factors. Even in the routine work of a child-guidance clinic, the mental hygienist comes face to face with every single social phenomenon at some time or other. Not only the more immediate primary phenomena, such as family relationships, but the wider experiences of society at large, such as labor, immigration, war, the movies, and the Hoover campaign have their bearing on his daily

work. This may not be a purely monistic view; if it is not the different-aspect-of-the-same-thing hypothesis, it is at least an interactionism. It is the stand that Dr. Groves takes throughout his writings. He says: "Social experience cannot properly be thought of as something impersonal which has existence apart from man, nor can man rightly be thought of as a being outside social contact." Again, social "experience becomes so much a part of each personality that no individual can be understood apart from it".

Ever since *Personality and Social Adjustment* appeared, we psychiatrists have felt that Dr. Groves is one of us, and have awaited each new contribution of his with avidity. Hence this review.

The book is, as the name implies, for the beginner who is unfamiliar with logical social thinking. After an introduction written for college students embarking on the study of sociology, the author arranges the subject matter in the following logical order: *Man and His Social Equipment; Man and His Social Experience; Man and His Social Organization; Man and His Social Failures; Man and His Social Resources.*

The section on man's social equipment is clear, concise, and sane. The author steers a middle course between the extremes of all instinct and no instinct, between heredity and environment. Man is "conceived of as fundamentally a reacting organism". "Not only is he in part a social product, he is also a contributor to the social situation that helps mold himself and others." "In his social behavior he is, like the most simple organism, taking in stimulations and giving out responses which in turn modify the environment from which his stimulations are received."

It is interesting to note the list of "psychiatric mechanisms" that Dr. Groves sets forth as useful in the understanding of human conduct—the unconscious, introversion and extroversion, identification, sublimation, projection and introjection, rationalization, ambivalence, and the wishes. These concepts he explains and illustrates in short and clear terms.

As might be expected, the chapter on the development of personality is specially illuminating and stimulating. "On this hereditary foundation of physical and intellectual variations are built . . . by the process of social contact the peculiarities that mark one person from another, which we call personality." He leads us through the development from infancy upward and sets as a goal the integration of the adolescent. In discussing adolescent conflict, he says, "Since the social circumstances are so largely the creation of adults, juvenile delinquency reveals, with the accuracy of a clinical thermometer in measuring fever, the state of society as young life strikes against the

construction built by the elders." "Sublimating and retarding of adolescent sex attraction" permits further growth and "the checks which modern culture brings upon the individuals to prevent precocious marriage and reproduction do not in the end prove hostile to the integration of the personality. Premature settling of the personality is prevented, for the purpose of integration on a much higher level even in the realm of sex." An eloquent answer to the back-to-nature-and-free-expression advocates. The adolescent's desire for emancipation is stressed, but at the same time "his lack of experience makes it necessary that he shall still have guidance or he is likely to make mistakes in conduct which later cannot be rectified and which he always will regret".

Among the social experiences of man, as given by the author, the psychiatrist is interested in conflict. This is of special significance to the development of the child. "The character and frequency of these episodes [the child's protest against coercion] often have a determining influence upon the growing personality, of the greatest significance in determining the adult's social conduct."

In the section on social failures, the author discusses social problems, their causes and their prevention, including under the latter the modern mental-hygiene movement, with its surveys, child-guidance clinics, and other activities. He clearly depicts in a few words the evolution of the old custodial psychiatry into present-day extramural preventive work. His searching criticism and defense of philanthropy reveal it as a social resource of great value in the world of to-day. While he decries the propagation of defectives and the unwise philanthropy of "mischievous charity", yet he enters a plea for the value of the "biologically weak" and the altruistic sentiment which reminds us that we have advanced apace from the level of brute savage existence.

As man's social resources, Dr. Groves gives play, art, science, and education. Of adult play, he says, "If wisely carried on, this will make a satisfactory attack on our crime tendency. Society ought always to provide the means to satisfy the craving for recreational self-expression; much of the mischief that appears in society is the result of emptiness in the play life." Regarding the school he says, "Increasingly our schools are not merely the guardian of past culture, but the medium through which social achievement is made possible." "It belongs to sociology as a science to do its part in keeping clearly before teacher and administrator the aim of education, superior adjustment for the individual and a more adequate social experience for the group."

One notes that religion is not given as a resource, but is included in

the section on social organizations. If a social resource is social experience and social behavior that can be used constructively, it is conceivable that religion might be so classified. It is at least a factor of social control. However, not all the influences of religious experience and the church make for social progress. Hence, we feel that Dr. Groves is justified in his present classification.

In this section on social resources, Dr. Groves also gives a stimulating discussion of social progress. The abstract question, "What is the goal of human achievement?" he relegates to the realm of social philosophy and cautions us to "keep the question of progress related to the concrete problems of life". Then "its test is advancement toward a more desirable type of living". That he does not undertake to define, but his idea of it is readily gathered from reading the book: it would seem to lie not so far from Dr. Putnam's famous definition of health—adjustment to present surroundings, capacity to adapt to new surroundings, and progress toward some ideal. This ideal must be an individual matter, determined largely by the individual's experiences. The goal is never a static one. "For society, as for the individual, it is continued growth. . . . Social progress is group life going forward, but its essence is in the life rather than in the movement."

Throughout the book, Dr. Groves speaks with the genetic, dynamic point of view. He is constantly referring to origins as seen in primitive people—namely, the child and the savage. In this light he presents the greater part of the subject matter of sociology. The book is, therefore, far more fascinating reading than the average textbook. It should be read by every psychiatrist.

ARTHUR R. TIMME.

Child Guidance Clinic of
Los Angeles and Pasadena.

THE MOTIVES OF MEN. By George A. Coe. New York: Charles Scribner's Sons, 1928. 265 p.

Thirty short essays, expanded editorials, some of them little sermons, in a handy volume. We can easily believe that the lectures at Yale Divinity School, which formed the basis of this book, were well received, the material is so fresh, so up-to-date, the style so trenchant.

Professor Coe's topics are loosely strung on the thread of human motivation. They start with the question what human beings are capable of wanting and what they are capable of doing with their wants. The author sounds a discreet note of pessimism and a cautious optimism. We may become, we may achieve, if, and if, and if. There is no surcharge of emotion, leading the author to feel himself in any

position to make predictions. His is a well-balanced statement, in all good humor, of things as they are at the present stage of human affairs.

Many pages are hugely enjoyable on account of their wit and insight. The author is all for progressive education, for the better understanding of childhood development, and for the best that there is in psychiatry. One of the cleverest chapters is in the form of imaginary conversations between representatives of the various schools of philosophy, with the Sphinx as listener in. At last the Sphinx says to the assembled spokesmen of the various psychological outlooks: "When you find out what you want, I hope you will one and all get what you want, provided you care to have that kind of a want." As for the Sphinx, she will go back and brood over these things for a few more thousand years.

Yet Professor Coe is by no means against investigation and discussion. Evidently he has read copiously in the new psychology. He is not afraid of it. He faces fearlessly the "diabolism" of the unconscious. Yes, and even within sound of certain disquieting rumblings from the market place and some of the high seats of psychiatry concerning the unworthiness of much psychoanalytic practice, Professor Coe speaks of the strengths of the situation when "in front of the patient whose mind is supposed to be a den of wild beasts, sits the psychoanalyst himself, a self-controlled, benevolent, and high-minded man".

A wide gamut of topics is ranged over in this little volume, but none are better handled than those that deal with matters nearest to the interests of the psychiatrist.

William Healy.

The Judge Baker Foundation, Boston.

Domestic Discord, Its Analysis and Treatment. By Ernest R. Mowrer, with the collaboration of Harriet R. Mowrer. Chicago: The University of Chicago Press, 1928. 277 p.

This book is an excellent example of the present rapprochement of sociology and psychiatry and of the fact that for them there is in many situations a common goal and the opportunity for a joint approach. The Mowrers have done an excellent piece of work, largely devoted to methodology. The tale is unfolded in the fashion of the up-to-date sociologists, the pattern being that of the University of Chicago group—and, at that, a mighty good pattern.

Any attempt to uncover the real meanings of domestic discord must rank with the endeavor to get at the bases of delinquency and crime—they are both immensely important for the advancement of

our civilization, and when the attempt is as fundamental as is represented in this little book, it is to be deeply reckoned with.

Psychiatrists who are connected with social-welfare work or who in private practice attempt to handle family problems would do well to take note of what the authors set forth by way of relatively short discussions of techniques—"order-and-forbidding", "persuasion", "the case-work approach", "particularistic techniques".

Psychiatrists come out rather second best in treatment, it seems, and apparently for good reasons. Their main "implication is that mental difficulties are often basic in the conflict between husband and wife". Or they insist that marital difficulties most often rest upon sexual incompatibilities. Mowrer's criticism of these attitudes and the treatment based on them is that they represent a standpoint too particularistic. Such attitudes lead to dealing with certain phases of domestic relations as if they were concrete units or with physiological and psychological processes as if they were static entities. The entities themselves are "usually considered inherited" and treated as explaining the situation, which is more really one of interaction between husband and wife. The psychiatrist's explanation is not in terms that take such interaction into account. The reviewer believes that much of this criticism is well deserved.

But then case-work at the hands of a welfare organization is largely based on diagnoses made in terms of overt behavior or of the economic situation, and little or no attempt is made to get at the genesis of the discord. The authors deplore this also and suggest that a more fundamental approach to the problems of family discord "requires a higher degree of objectivity, growing out of an analysis that has some organic continuity". A case is given in illustration of this possible method of treatment. The book comes to a climax with this more properly studied and treated case of domestic discord and with the thesis that the better treatment centers chiefly about the "causal situation" or "causal factor".

A philosophic bent is displayed in two of the chapters, and the authors throw a sop to the statistical Cerberus by adding numerous footnotes that give the percentages of "standard errors" in the tables. But the tables themselves represent compilations of superficial questionnaire facts that the single case, given in detail, would show to be just the sort of facts that are of very little value for handling the situation. Then do such appendages of statistical method done in the fashion of the day add to scientific validity? Our guess is that the best statisticians would not say so.

We leave the book saying to ourselves, "And so domestic discord is coming in for 'clinical treatment'." But what the meaning of a

clinic is grows less and less clear, and the reviewer rather sympathizes with our Continental friends who ask how in the world Americans use the term. Confusion rather grows as Mowrer suggests two plans for a "clinic" for domestic discord, in one of which there is a psychiatrist with the other workers, while in the other the "clinic" staff consists of *two sociologists,* one man and one woman, and a secretary. If necessary the discordants can be medically and psychiatrically examined elsewhere.

So far as the treatment is concerned, we are inclined to agree with Mowrer and feel that in any case it is "the organic continuity" of it that will count.

WILLIAM HEALY.
The Judge Baker Foundation, Boston.

ANTHROPOLOGY AND MODERN LIFE. By Franz Boas. New York: W. W. Norton and Company, 1928. 246 p.

Formulations of scientific data in terms intelligible to the layman and their application to the solution of broad life problems are as rare as they are desirable. For although the spirit of all scientific research probably owes its origin to the desire of man to understand his environment, science has come to include so many diverse fields and interests that it usually loses sight of the original starting point. In most cases the student of a special branch of science either loses himself entirely in his specialty or, if he attempts broader applications, expresses himself in language intelligible only to a few specialists.

Both of these difficulties have been admirably overcome by this author. Starting out with the definition of anthropology as a science that "treats of man as a member of a social group", he proceeds to show how the wealth of knowledge gained by this science can be applied to the understanding of modern life. Such an approach to the study of human behavior would, of course, be justified only if it could be shown that the characteristics peculiar to any group (such as race) are not rigid, hereditary factors and that culture in itself is not a constant, but can be influenced by changes in these characteristics.

For this purpose the author takes up the discussion of two basic concepts—race and stability of culture. The first question that would come up, in an analysis of the concept "race" from this point of view, would be the existence of such things as racial characteristics that can influence human behavior in one way or another. By these one would understand anatomical or functional features that are always found in all members of a given race, and that could really be looked on as hereditarily transmitted and therefore constant factors. However, an analysis of characteristics that are usually spoken of as racial shows that they really belong to groups within certain races

rather than to the race as a whole. Anatomical features, for instance —such as a certain intensity of pigmentation, form and color of hair, and so on—may differ more between extreme groups in the same race than they do between certain groups of different races. Whatever conditions might have existed ages ago, at present, largely because of the improved interrelations between races, these features have shown an increasing tendency to spread from one race to another and have remained as characteristic features only in certain isolated and, therefore, inbred groups. That which is at present looked upon as a race really represents a "closed system", probably united more by economic or emotional bonds than by any so-called hereditarily transmitted racial features. This also applies to nations or even to nationalities where the characteristics spoken of as types really belong to certain groups within the unit rather than to all members of it.

If this be true of antomical features, it is even more so of functional, and the author reaches the conclusion that no particular functional feature can be spoken of as characteristic of any given race or nation. In other words, any such feature could just as well be found in an isolated member or members of another unit, as it could be absent in one of its own members. It could be shown, furthermore, that the features that are peculiar to a special group are not merely hereditarily transmitted constants, but are influenced by the special situation in which members of that particular group find themselves by virtue of belonging to that group. The fact that the environment of the individual as created by the group is of the greatest importance in molding his character and determining his behavior can also be applied in our approach to special practical measures. A system of eugenics, for instance, would consist in an organized attempt at creating an ideal environment within the group rather than an attempt to weed out undesirable traits by control of matings. A similar point of view is taken in the study of criminology and the control of it.

From this point of view, one can hardly regard culture as something definitely established and permanent. It is rather an ever-changing process which has nothing of permanent value in it excepting the fact that it is always determined by an interaction between the individual and the environment as it is found in the particular group. In fact, a permanency of standards either in the group or in any member of it would not be as desirable as it may seem. It would make for rigidity and poverty of adaptability in approaching new problems. Knowledge gained by anthropological research can also be practically applied in outlining a system of education in which a faculty of easy adaptability to changes in environment rather than rigid "automatic habits" is to be developed.

There is a great deal that is new in this book, and, as is usually the case, a great deal that conflicts with previously established standards. This, however, is perfectly counteracted by the lack of dogmatism. Statements are either solidly supported by facts or offered only as working hypotheses. If the views expressed go somewhat against the grain of the avowed nativist, he cannot help but admit that they are well supported by actual experiences. To those of us who are making efforts at mental hygiene, social as well as individual, the value of studies that show the importance of environment in determining human behavior is, of course, self-evident.

WILLIAM MALAMUD.
Foxborough (Massachusetts) State Hospital.

RELIGION COMING OF AGE. By Roy Wood Sellars. New York: The Macmillan Company, 1928. 293 p.

What of religion in the flux of new ideas, new knowledge, and new approaches to old knowledge that makes up modern life? Professor Roy Wood Sellars seeks to answer this question in his book, *Religion Coming of Age,* one of the "Philosophy for the Layman" series, published by Macmillan, of which he is the editor.

In this book Professor Sellars plunges boldly into the stream of modern thought and seeks to define the sphere of religion. What he has to say, it must be confessed, will not carry great comfort to the Fundamentalists, but he does offer a way out for those who are coming to be increasingly conscious of the discrepancies between modern science and traditional religion. Recognizing the high service the church has performed in the past, with its insistence on ethical and moral values as part of a conception of religion, he discards much that has come to be accepted as a vital part of religion and in its place offers the ethical and spiritual values of life as it is lived here and now.

The old dualism, which up to very recent times was the practical foundation of all religion—the body to be mortified and the soul to be exalted—he rejects in favor of "evolutionary naturalism", maintaining that true religion expresses itself in participation to the fullest extent in the vital and expanding problems of the life around us. There is small place for the supernatural in Professor Sellar's view.

In the earlier chapters the author discusses the philosopher's view of religion, reviews the development of primitive beliefs, traces the evolution of Christianity, and (Chapter VIII) surveys the present situation, considering "Modernism" and "Fundamentalism" from a philosopher's point of view. In later chapters he deals with traditional riddles. *Was the Universe Created?; Time and Space; The Riddle of*

Life; Can Religion Dispense with Immortality?; and *Has Man a Cosmic Companion?* are suggestive chapter titles for any one who has thought at all on religious matters.

Many may be inclined to dispute certain of Professor Sellars' conclusions. They may feel that he emphasizes mechanical and scientific conceptions at the expense of spiritual values; that, in denying some of the most fundamental things for which religion has always stood, he has set up a pale, formalistic conception which lacks the warmth that the old religion has always shed. But the author insists that this is not necessarily so—that there is sweetness and light in the new view which, whether we realize it or not, is changing the whole texture of modern spiritual life.

W. B. Shaw.

University of Michigan.

Ethics. By Frank Chapman Sharp. New York: The Macmillan Company, 1928. 566 p.

One might get the idea from looking over the lists of recently published books that works on ethics were no longer being written and that the subject as a whole was rather reactionary and old-fashioned, but the nucleus of what used to be called moral philosophy still survives, and here is a work that undertakes to cover the subject in its present-day ramifications.

As one turns over the pages of this easily written and easily read book, one recognizes that the trend of the times has for too long neglected the question of values and that it is well to be called back to their consideration. To be sure, values have a very exquisitely individual and personal meaning, but they have, too, a broader significance which is laid down in the culture of the race and with which every one of us must necessarily deal, no matter how skeptical or critical we may be of special formulation. It is true that it is quite easy to discount ethical considerations and translate them into formulæ of utilitarian significance, but even if we do undertake to prove that everything altruistic is only another form of egotism, we must nevertheless admit, as Barbellion says, that "the selfishness of a wife-beater is lower than the selfishness of a man who gives up his life for another". And so we have in Professor Sharp's book an excellent discussion of contemporary ethics—what constitutes right conduct, and what is wrong, and why. To be sure, it is all discussed at what the psychoanalytically trained would say was a rather superficial or perhaps higher descriptive level, but that does not mean that it is without value, for it is matter at the descriptive level that has to be taken hold of by more profound interpretations, and then one gets from the book that flavor

of the trained teacher, the personality capable of carrying the student along with him and enthusing him, and so one feels that back of this book there is not merely a discussion of morals, but a moral force itself.

W. A. White.

St. Elizabeths Hospital.

The Religious Development of Adolescents. By Oskar Kupky. Translated by William Clark Trow. New York: The Macmillan Company, 1928. 138 p.

Although this is a small book, it contains a surprising amount of material. The author evidently has an excellent background for the study and refers freely to other books on the psychology of religion and adolescence. The original data presented consist of the diary notes of boys and girls, poems of a religious nature, and the "religious confessions" of three individuals. It is unfortunate that these data have been obtained from such a limited number of adolescents; altogether, only sixteen are represented. This first-hand material has been supplemented, however, by a study of biographical novels and reports of the findings of other investigators.

The ambitious scope of this miniature volume may be deduced from the following chapter headings: *The Psychology of Religion; The Religion of the Child; The Progress of Religious Development; The Direction of Development; Beginning and Duration of Development; Love and Religion in Adolescence; The Intellectual Unity of Youthful Religious Development; Socio-ethical Influences; Æsthetic Influences; Youth's First Religious Experiences; The Main Outlines of Religious Development.* In view of the wide territory that the author attempts to cover, it is somewhat regrettable that he did not permit himself more pages. By condensing his material into the present small volume, he runs considerable risk of laying himself open to the charge of dogmatism.

Kupky classifies the religious development of the adolescent into three types: the continuous, in which there is a slow, but entirely consistent growth without any wavering of faith; the catastrophic, in which the element of conversion is prominent; and the mixed, in which there are violent emotional experiences and even periods of doubt, although the continuity of the development is not permanently interrupted. Of the complete loss of religious faith, he says altogether too little, simply indicating that the religious emotion becomes attached to some other ideal than service of God, such as socialism or science.

It is interesting to note that Kupky is distinctly critical of the work of American psychologists with regard to religious development in adolescence (although he quotes from them rather frequently). It is

also impossible for him to accept any of the psychoanalytic theories—"for they are theories and not facts" (page 68)—which treat of the relationship between sex and religion. That there can be any element of sexual emotion in religious experience, Kupky refuses to admit. He cannot accept even the concept of guilt as based on reactions to sex perversions. "But when it is maintained by psychoanalysts . . . that onanism and similar sexual perversions precede youthful consciousness of sin, then surely this claim goes too far." (Page 73.) Apparently in Leipzig, as in America, there are some psychologists who find psychoanalytic facts (not theories) too shocking to permit of tolerance.

PHYLLIS BLANCHARD.

Philadelphia Child Guidance Clinic.

SCIENCE AND GOOD BEHAVIOR. By H. M. Parshley. Indianapolis: The Bobbs-Merrill Company, 1928. 281 p.

I suppose one might put the annual production in America of books on good behavior at three thousand titles, with a total circulation of at least two million copies. There are books on theology, books on religion (note the distinction), books on morality, books on mere ethics, sermons, philosophies, commentaries, explanations of holy documents, exhortations to the good life in honeyed words, dissuasions from evil on pain of hell fire, due notices to practice our brand of behavior or go to jail. Whole forests are depleted to keep this stream undiminished. And what does the public get? Rhapsodies of absurdity, paradoxes, inconsistencies, mysticisms, twaddle. The reviewer offers his best offices to procure free board and lodging for life to any one who can show a single intelligent thesis in a book of this type, humanism only excepted; and he believes that his acquaintance with distinguished alienists is wide enough for him to make good.

Seriously, this output of holy bunk is the most barbarous characteristic of an otherwise progressive age, for it is a vestigial remnant of primitive social method carried over into a society that has adopted the scientific method for its other activities. Why such inconsistency? Because the medicine man and witch doctor still plays on our fears, and through them rules, just as he has done in all other eras.

There is only one possible method for gaining relief from the intolerable situation thus constituted. It is to turn to science, to study good behavior objectively, to gather the facts, to draw just conclusions from the facts, and to act upon these conclusions boldly. Dr. Parshley has shown how, in a book filled with sense and written with a clearness, a unity, and a beauty that are beyond reproach.

Dr. Parshley is a biologist. Why should a biologist take this theme?

Because it is a biological theme. Man is an animal. He is urged by hunger, sex, and fear. He is banded together into society to safeguard his own survival. His every act, from infancy to old age, is conditioned by his inheritance, his physical environment, and his education or mental environment. The subject belongs by right to biology. In fact, the moralist who has had no training in biology has no more license to write on ethics than Billy Sunday has to talk on relativity.

Half of *Science and Good Behavior* is given over to elementary biology, to showing the reasons why social problems are biological problems. And the task is well done. If the reader can go through the first five chapters carefully without wanting to know more of the biological roots of his thoughts and actions, there is something wrong with him. But these chapters are only the cocktails and soup of Dr. Parshley's party; the last five chapters are the meat. There one finds the reason for the work. We must regulate social behavior, if we are to achieve a society worth having, says the author; but these regulations should have as their sole goal all the freedom and happiness of the individual that is consonant with the freedom and happiness of all. How shall it be done? Not by theological dictators. Their dogmas make no appeal to intelligent men, and therefore cannot be sound for unintelligent men. Nor will codes of morals handed down from savage times and based upon adaptations of the primitive taboo serve any better. What society must have is a system of ethics based upon tangible human needs and desires and determined by objective inquiry.

The theological doctors will in part rave at such a program, saying that science is not only blind to man's aspirations, but is also unsympathetic, and therefore unqualified to deal with the case. This statement is patently untrue; for science only says: Do not tell us what we must and must not do to be saved, basing your deductions on personal interpretations of holy dogma which is manifestly absurd; instead, search diligently and wisely, with care only for the truth, to find out man's real needs and then seek to satisfy them. A second moiety of theologues will say that there is no quarrel between religion and science. Stuff and nonsense! The theologues are trying to hold their jobs. There always has been, and, with the historical conception of religion, there always must be a quarrel between religion and science. The foundation of science is the objective demonstration of facts; the foundation of religion is faith in undemonstrable postulates. If religion is to side with science, it must adopt as its sole principle the saying which Paul (I think) wrote in an unguarded moment: "Prove all things; hold fast that which is good (true)."

Dr. Parshley will also receive a few jolts from the metaphysicians—

probably below the belt. They have no more desire to face facts than the theologues. The only difference between the two is that the latter believe in a universe which primitive man created several thousand yars ago, at a time when the whole race was as ignorant as the Fuegians; while the former create their own universes individually.

It is a great book, an interesting book, a helpful book. It is to be recommended far and wide, for it contains just what all logically minded scientists have been thinking, but have been too timid to voice. In particular, the members of the younger generations should give it their attention; it will give them new ideas, new hopes, a sane outlook on life.

E. M. East.

Harvard University.

Pupil Adjustment in Junior and Senior High Schools. By William Claude Reavis. Boston: D. C. Heath and Company, 1926. 348 p.

This book is largely a description of the "case method" in use at the University of Chicago High School, of which the author is principal.

The author devotes the first four chapters to the general problems of pupil adjustment, the history and development of the methods used, the need for individual guidance, and the description of a technique.

The two chapters describing the organization in effect at the University High School for the study and guidance of maladjusted pupils is truly a revelation of what may be accomplished toward salvaging the enormous number of boys and girls who drop out of school between the ages of fourteen and eighteen.

Dr. Reavis supplements his description of the "case method" with a detailed description of nine maladjusted pupils who came under his own guidance. In these case histories the aids upon which chief dependence appears to be placed in the readjustment process are medical examination and supervision, various psychological tests (notably the Terman group test and the Downey will-temperament test), regular periodical reports of progress for the information of both pupil and parents, individual "heart-to-heart" talks with the pupil who is failing, and conferences with the parents.

The reviewer was impressed with the emphasis placed on physical examination and supervision. The reader is actually initiated into the method of conducting a physical examination, and learns that it involves such things as inspection, palpation, percussion, and auscultation. For more complete information on the subject, one is referred

to the appendix which lists 27 references on physical diagnosis. Reading the case histories, one grows weary of the oft-repeated references to height, weight, and chest measurements, and the history of chicken pox, measles, or whooping cough in the records of boys who are failing in Latin or mathematics. But let us see what are the causes of academic failure. A classification is given of the causes of failure of 78 boys at the University of Chicago High School for the period 1921 to 1924. Of these only 10 failed for reasons of physical disability while "ineffective habits of work" claimed 22 and "personality difficulties" 17. Now the last heading would appear to fall within the scope of mental hygiene, as probably would also most of those labeled "ineffective habits of work", yet in the entire book there is no mention of mental hygiene, there is scant reference to psychiatric literature, and of the psychiatrist one reads, "If he is able fully to utilize the scientific findings of physicians, psychologists, and educators as bases for further exploration into uncharted regions, his discoveries in turn may come to have similar value for those whose work lies in other special fields."

Dr. Reavis' book is a pioneer contribution. Perhaps its chief value is its challenge to educators, in calling to their attention a remarkable achievement in pupil guidance in a public high school.

H. N. Kerns.

Yale University.

Introduction to the Technic of Child Analysis. By Anna Freud. Authorized translation supervised by L. Pierce Clark, M.D. New York: Nervous and Mental Disease Publishing Company, 1928. 58 p.

Anna Freud's little book is made up of four lectures delivered before a group of psychoanalysts and teachers under the auspices of the Instruction Department of the Vienna Psychoanalytic Association.

In these lectures the author discusses her unique experiences as a child analyst under the following headings: (a) preparative steps; (b) methods of child analysis proper; (c) the peculiar problems of transference in child analysis; and (d) the relation of child analysis to education. Specifically, the experience discussed is based on the results of ten complete, long-term analyses of children.

The first problem discussed is what child cases constitute proper material for analysis. Contrary to the opinion of certain pedagogues, who advise psychoanalytic treatment in all cases of disturbances of even minor character, Anna Freud is inclined to restrict such treatment to fully developed, unmistakably indicated infantile neuroses. A line of differentiation between these conditions can be drawn pretty

sharply, and there should be no difficulty in singling out cases that would justify the really great effort and serious work involved in child analysis.

This leads to a parallel between psychoanalysis of a child and psychoanalysis of an adult. It is quite obvious that analysis of a child differs from that of an adult. An adult always has a degree of insight into his disease and generally is infinitely more aware of his troubles than a child can be. An adult applies for analysis by an act of volition, while a child is brought to the analyst. An adult has a conscious desire for recovery, in spite of unconscious resistance, while a child, of course, cannot be expected to have such desires. The author goes too far in summing up these differences when she states that "the adult, at least in the majority of cases, is a mature and independent being in opposition to the child, which is immature and dependent". A neurotic adult is also essentially immature and dependent, though of course not in the same degree as a child. The adult neurotic has merely a richer life experience and a much more differentiated and compulsive code of morals and conduct. The author practically admits this in a later part of the book.

Naturally, differences of so important a nature are bound to have a great bearing on the organization and methods of child analysis, requiring modifications in standard analytic technic.

It requires unusual intuition and native tact, besides a box of tricks, to gain the child's confidence. Anna Freud, by a series of remarkable records from her own experience, shows that under especially favorable conditions the child may even be made to gain some insight into the neurosis and to produce a willingness and a consequent desire for recovery.

There are further modifications necessary in analysis of neurotic children. With the child, the analyst must break away from his attitude of full reserve with reference to personal affairs, must forego absolute sincerity and truthfulness, and must deprive the patient of the liberty to discontinue analysis when desired.

On the other hand, standard analysis of dreams is not only perfectly applicable in child analysis, but in most cases even more effective than with adults, since dreams are more real to the child. (Miss Freud charmingly goes in company with the child in search of every piece of the dream, wherever it comes from.) The author stresses the importance of daydreams and "continued stories", substantiating her argument with very interesting examples.

Children's drawings have proven to be a very fruitful method for establishing the needed access to the unconscious life of the child. This is also illustrated by a series of remarkable examples.

Modification in the technic of *free associations* is discussed very fully. The child may be led to associate, but will do so largely in order to please the analyst. This will not last long. The child, not understanding the importance of the process, will soon tire and give it up. Therefore, various substitutes for free association have been suggested. The late Dr. Hug-Hellmuth suggested games in the child's home environment. Mrs. Melanie Klein experimented with an imaginative outlet of little toys by leading the child to make up stories about them, the toys being dramatis personæ. Each act invented by the child was given its symbolic interpretation. This *playwright technic* the author rejects for very good reasons which cannot be outlined briefly.

A whole chapter is devoted to the rôle of transference in child analysis. The author takes the position that in child analysis no *transference neurosis* is established, mainly because the child exercises no restraint at home and, consequently, finds no specific outlets in its relation to the analyst. Only when the child is removed from its home does the analyst become the exclusive and proper target of the child's positive and negative reactions. Other quite interesting, though disputable, arguments which the author brings forth in discussing this subject will be omitted here.

Coöperation with the parents is essential in child analysis. The child cannot be relied upon to give the history of the case; the parents must do it. Furthermore, the analyst becomes in a sense a member of the parental group contributing to the training of the child, and as such must insist on harmony in the group, which, in practice, means full coöperation on the part of the parents. The author is so emphatic on this point that she rightly refuses treatment unless this harmony is fully guaranteed.

The fourth and last chapter is possibly the most interesting and rich in ideas. The author discusses the advantages and disadvantages of child analysis. While the material of the first two years of life is easier to penetrate with the child than with the adult, the period before articulation remains in the dark. In comparison to this, the free-association technic, plus interpretation of transference reactions in adult analysis, are far better able to reveal this remote period.

The chief task of analysis is to elevate the conflict between the instinctive, unconscious impulses, the ego, and the super-ego to a level where influence will reach the super-ego more forcefully. The super-ego, in the child, is naturally weak and dependent. Hence, the outer world will influence the infantile neurosis more deeply than that of the adult. In addition to this, the *double morality* of the child, with regard to shame and distaste—one moral code for facing

the adult world and one for facing the child world—requires still further modifications. "The analyst must analyze and must educate, must in one breath permit and forbid, loosen and hold in check again."

Having discussed the specific difficulties that arise from these essential modifications, the author closes her subject by setting forth the prospects and great possibilities of child analysis, which may be summarized as follows: (1) Analysis, with the child, need retrace but a short distance in order to establish a normal path for future development. (2) The fact that the infantile neurosis developed through conflicts that to a great extent center around still living parental images makes, under favorable conditions, correction of its super-ego easy and promising. (3) In view of the fact that the requirements of the child are comparatively simple and easy to satisfy, modification of the environment to suit the child's needs is possible. This, with adults, is naturally a more difficult task.

The lectures are presented in an exemplary style, direct and clear. The author is above all disinclined to vaunt superior knowledge and to assume a didactic rôle. She avoids exaggerations and embellishments, and proves herself incapable of sacrificing truth for the convenience of smooth, rounded-out, dogmatic statements and conclusions. We are just beginning to appreciate the processes of child psychology, and it is gratifying to note that the author does not cater to the public, which likes to be treated with definite, though not always reliable suggestions. With these qualities, her little book will be invaluable in offsetting the many bulky books on child psychology that appear daily on the market. It doubtless will meet with the generous approval of the serious-minded worker in the field of child psychology.

The suggestion might be made that in the next edition the translation follow more accurately the intrinsic sense of the original and thus avoid the confusion that exists in a few passages at present.

Dorian Feigenbaum.

New York Psychoanalytic Society.

The Behavior of Young Children of the Same Family. By Blanche C. Weill. Cambridge: Harvard University Press, 1928. 220 p.

Miss Weill has given us a painstaking study of the family and the part it plays in determining behavior and personality development. As a background for her study, she presents a wide range of theory drawn from the fields of the early environmentalists, Darwinism, endocrinology, psychoanalysis, individual psychology, behaviorism,

criminology, sociology, and mental hygiene. Developments in these fields, it is stated, show an increasing emphasis placed on the importance of environment over heredity in determining behavior and personality development. The author uses the scientific method of stating a hypothesis, furnishing evidence, and drawing conclusions. Unfortunately, this method creates a sense of authority that is not substantiated by an analysis of her material. Her hypothesis is that each child occupies a unique position in the family group and accordingly has an individual environment that is responsible for his behavior and personality development. Proof of this statement is sought in a study of 17 families embracing 59 children, of whom 25 are problems. The family situations are classified under the headings (1) poor personal relations, (2) mental and physical disabilities, (3) social and moral maladjustments, and (4) economic pressures. Under each heading, there are numerous subdivisions. The effect of this effort at classification is that of a smoke screen, and the real issues remain obscure behind a network of labels and formulæ.

Sex, position in the birth order, kinæsthetic sensations, rhythm (of heart beat, circulation, sleep, food, et cetera) and voices (quality of voices of those in the environment) are given as the factors that combine to form the conditioned responses by which the child learns to adapt himself to life. Why these factors, which are present in the life of every child, should operate to produce maladjustments for some children and not for others is left unexplained.

We accept the author's hypothesis that each child has an individual environment which largely accounts for differences in development, but we feel her argument is inadequate because she does not give sufficient weight to that fundamental relationship between parent and child which so largely determines the child's reaction to his environment. Her measuring stick is too readily adjusted to her case material, and she ignores underlying problems that cannot be explained by her formula. The four main attitudes that she recommends to parents—unswerving consistency, unconcern, keeping of promises, and telling the truth—hardly seem the cardinal virtues of parenthood. These are superficial values, arbitrarily chosen and difficult to interpret. The essential need is that parents give the child emotional security, keep themselves free from handicapping identifications with him, and furnish incentives for his final emancipation.

The author has accumulated a wealth of valuable material, but the theoretical explanation of her thesis is too unintegrated to be convincing.

Elizabeth H. Dexter.

Department of Child Guidance,
Newark (N. J.) Board of Education.

KEEPING MENTALLY FIT; A GUIDE TO EVERYDAY PSYCHOLOGY. By Joseph Jastrow. New York: Greenberg Publisher, 1928. 297 p.

This volume consists of a series of daily articles published under the direction of the Public Ledger Syndicate of Philadelphia. The fact that it is made up of short articles results, unfortunately, in a lack of logical sequence, but the book makes interesting reading, particularly for the layman, and may be taken up at odd moments without any loss of continuity of thought. It should be of value from the standpoint of entertainment, as well as for the general information it contains along psychological lines.

Many popular questions are answered in a popular way, with more or less of a scientific background. Some unusually interesting psychological mechanisms are discussed, and a chapter that is devoted especially to child guidance should be helpful to parents. "The mental code for every child", which contains seven definite instructions for the training of children, should be of value to every parent who is interested in child psychology.

It is rather interesting to note the attitude of the writer on the question of heredity versus environment. He sums up the situation as follows: "All of us have been twice made, the first time by the nature which we inherit, the second by the training which we receive."

His attitude toward criminology indicates his progressive spirit and his psychiatric background. He outlines briefly the present situation with reference to the treatment of criminals as follows: "Our whole system of treating the criminal is crude, because only recently have we permitted the study of the mind of the criminal to guide our practice. This is one of the many cases in which as we become more scientific, we also become more humane."

The various instinctive cravings of human beings are discussed in a very interesting manner, and Dr. Jastrow indicates how satisfaction is sought in various ways that lead to odd behavior. For instance, the seeking of power and esteem may be carried on in various ways, such as the accumulation of money, which may occur in individuals who are unable to accumulate friends. Dr. Jastrow shows further how this inability to make friends in turn is due to the personality traits of the individual.

In a brief review of this kind it would be impossible to bring out all the many interesting questions that Dr. Jastrow takes up. To mention a few of them, he discusses such timely topics as the following:

"What are you afraid of?"

"Can psychoanalysts help you?"

"Can cousins marry?"
"Are we slaves to our glands?"
"Have you an inferiority sense?"
"The psychology of the lipstick."

The last chapter gives a number of typical cases, which, after all, is probably the most effective method of expounding the art of mental hygiene.

Briefly, one might characterize the book as a practical application of the new psychology to the everyday problems of life. Every reader will undoubtedly find one or more personal questions answered to his satisfaction, and will, therefore, derive some special benefit from the volume.

Dr. Jastrow makes light of many slight defects that annoy and worry some people, so the reading of the book itself might be considered a good mental-hygiene measure, quite apart from the value of the explanations given.

There is a very distinct avoidance of scientific terminology, which again should help to make the book popular among lay, as well as among professional, readers.

H. A. Steckel.

Binghamton State Hospital.

Science and the Religious Life: A Psychophysiological Approach. By Carl Rahn. New Haven: Yale University Press, 1928. 221 p.

This is not a book that is easily read; both by reason of its style and its content, it is obviously intended for the more scholarly reader. It is filled with technical language and its thought is hampered by long, involved sentences. But the author's range of knowledge and thought are impressive. Quite clearly he is a student to be respected and heeded. The book is a stimulating study on its philosophical side, but it is less convincing in its effort at a psychological explanation of the scientific and religious attitudes, which is its main purpose.

As an apologetic for naturalism, it is excellent and quite chiding of the scientist's lack of insight into the religious possibilities of the world view implied by naturalism. Even those who have done all their actual work on the basis of the evolutionary hypothesis have, in what little or much philosophizing they have been guilty of, assumed the fact of biologic finalism. This is the doctrine that "the process of organic evolution has now evolved on earth that biologically stable species which shall remain in possession of the little ball until it grows cold and wrinkles with age". There is no basis either in the theory or the empirical data of biology for this assumption. By right, the heuristic aspect of the evolutionary theory, which is the

heart of it, opens up visions of a transcendent humanity as great in power of inspiration and hope as are built upon a theistic view. Naturalism has thus been made a dogma rather than a process of imparting a spirit of enterprise, of search, of quest, out of which living knowledge grows. This has sapped the initiative of the age and made it one of scientific specialists upon whose dicta the people wait as upon a new source of revelation, which, in principle, is a condition no different or more energizing than obtained in a theological age.

Granted, then, that naturalism has always been the point of view of enlightened ages and the culmination of culture epochs, Rahn's contention is that in the sphere of inner physiological chemical processes lie the possibilities of that changed humanity envisioned by religion and evolutionary theory alike. By a proper understanding, control, and reorganization of the physiological processes involved in the life of feeling, emotion, and mood, of desire and striving, new qualities of experiences might emerge. This is the proper task of any scientific approach to religious values, because, in Rahn's view, the future evolution of man will come in the field of internal chemical processes rather than in that of gross anatomical changes or in that of "societal" progress governed by metaphysical theories. Dr. Rahn dissociates the emotional attitudes of people, the idealogies or world views they hold, and the modes of action that they adopt. Theory, whether naturalistic or theistic, has no direct relation to mood or causes of action, since intellectual acceptance does not insure organic and muscular action of a uniform type or effect.

In any case, quality of life cannot go beyond the possibilities of the physiological instrument that contains it. There need be, however, no necessary limitation placed upon the possible changes in the instrument and, therefore, of the quality and range of values for life, but the field of advance lies in the endeavor to understand and control the physiological processes involved rather than in metaphysical theory dominating the intellectual outlook. No scientifically minded person would question the relationship of body and life. Religion, seen from the limitation thus set upon "spiritual" things, would be the summary and experience and direction of life at its best under the circumstances of its possibilities at any given time. Science's part is to be ever playing at the exploration and extension of the physiological possibilities.

All this is logical and plausible as analysis or description, but it leaves one rather flat so far as inspiration and challenge to action are concerned. One puts the book down a bit confused and puzzled, even with the realization that one has companied with a brilliant and learned mind. It might easily have emphasized the dynamic outlook,

rising nowadays with cumulative power, that makes of religion and science and life as a whole an embodiment of a spirit of adventure and creative enterprise, steeling men to a longing to be "drenched in the greatness and bitterness of the quest".

Without underestimating the importance of the evolutionary theory in the least, it is hardly wise to let biology bear the whole weight of life's values and possibilities. Rahn has made a contribution in calling attention to the neglected implications of evolution which he discusses, but philosophy and social science and the daily reverences of religion have great things of their own to do in the molding of a transfigured humanity.

PRYOR MCN. GRANT.

Toc H, New York City.

THE PSYCHOLOGY OF THE ADOLESCENT. By Leta S. Hollingworth. New York: D. Appleton and Company, 1928. 227 p.

We have to thank Dr. Hollingworth for the most sensible, simple, yet inclusive account of adolescence that has appeared since the era of mental hygiene, with its flood of literature on human adjustment.

Dr. Hollingworth has not permitted herself to be swamped by any one point of view. Adolescence is not presented as a physiological catastrophe, a psychoanalytic welter of complexes, nor yet as an anthropological left-over whose significance is to be sought chiefly in accounts of primitive societies. She accepts adolescence here and now in terms of the actual, not of the deplored present or of the lamented past. She is not filled with gloom over the behavior of our young people nor is she blind to the increased difficulties that our present-day culture imposes upon the sex and vocational expression of the youth in his teens.

The writer has seldom read a better balanced presentation. With the statistical behavioristic attitude so characteristic of Columbia, it combines an assimilation of many mental-hygiene principles which have filtered through largely from the analytic psychology. When to this is added adequate recognition of anthropological background, physiological basis, and social and economic factors, one has what might be called a scientific, common-sense view that will be highly informational to any parent and injurious to very few.

One who is emancipated from the psychometric fetish, or one who is overawed by the seeming finality of figures, might react unfavorably to the frequent reference to the I.Q. and its importance for understanding the phenomena of adolescence. To some of us who have given up trying to reduce the emotional life to figures or intellect, the following seems a bit over-simplified as an explanation of emotional

development: "When a 'mental age' of about 12 years has been reached, the question spontaneously arises, 'What shall I do with the years that lie ahead of me?' This question is now formulated for the same reason that religious questions arise. The intellect is sufficiently developed to ask it." (Chapter VII, p. 165.) As representative of the contribution of the book, however, this quotation is quite unfair. The surprising thing is not that Dr. Hollingworth, who has contributed so notably in the field of psychometric measurements, should emphasize the tools with which she has experimented, but that she should have succeeded in bringing into her picture of adolescence so much that is human, helpful, and enlightening.

Her chapter on "the psychological weaning" should be particularly useful to parents and perhaps to young people also. In fact Dr. Hollingworth intended to make her book practical for adolescents themselves.

Her discussion of mating is also praiseworthy for its balance and common sense. There is nothing in the emphasis on heterosexuality to strike terror to the hearts of parents because of an implied threat of homosexuality as an alternative, and little to arouse the antagonism and prejudice that any leaning toward undue freedom of sex expression for the young is likely to kindle. Yet she does not hesitate to say: "No one is likely to alleviate the maladjustments which at present arise who adheres to the belief that sexual impulse is in all its manifestations entirely under voluntary control, and is voluntarily initiated; that the impulse is psychologically connected by original nature with reproduction; or that it is by nature monogamous. False belief in any of these respects leads to misunderstanding and trouble." (Chapter V, p. 111.)

She recognizes that "the sex life of the child begins at birth", and that the establishment of heterosexuality is of fundamental importance. "For normal adjustment to life during and after the maturation of the sex organs, it is absolutely essential for both sexes that this heterosexual attitude be achieved. Yet under present conditions the guardians of youth—ministers, teachers, and parents—seem in a conspiracy to prevent the child from attaining a healthy development of sex interest. . . . Heterosexuality can be established in no other way than by social contact and actual acquaintanceship with those of the opposite sex. It does not develop in emptiness. Anything that deprives a person of these necessary contacts—during the years of immaturity, particularly during the years of adolescence—is not for his or her best interests as an adult."

The explanation of sexual perversion, so called, under the heading *Aberrations,* is a wholesome antidote to some of the hysterical warn-

ings that have been thrown at the heads of helpless, terrified parents by well-meaning supporters of an unassimilated analytic psychology. Dr. Hollingworth's treatment of homosexuality and auto-erotism, the only perversions definitely referred to, like everything else in the book, is of strictly behavioristic, conditioned-reflex character, which clears the surface of emotional rubbish even if it goes no deeper. "Let us now see how the adolescent may be emotionally trapped or caged, and be thus restrained from finding the normal outlet for his developing sex cravings. Let us repeat that in the earlier years the sexual drive is typically vague as to goal and hence liable to distortion. . . . There are various forms of sex conduct that give approximate satisfaction, and hence may be adopted in the unenlightened striving for adjustment, but are undesirable either because the individual fixed therein is prevented from achieving full happiness or because they are socially unprofitable. These forms of conduct are called perversions. They are acquired in accordance with the laws of learning, which govern all habit formation." (Chapter V, p. 130.)

The concluding chapters, *Achieving a Point of View, Finding the Self,* and *The Meaning of Maturity,* are less convincing than the earlier sections largely because such aspects of adolescence do not lend themselves to a behavioristic account. Something more than the conditioned reflex is needed to give reality to the emotional life of man, which refuses to be reduced to an intelligence quotient or a correlation table. While as a philosopher Dr. Hollingworth is out of her element, as a representative of what psychology can do for the everyday practice and enlightenment of the average man, she is outstanding. We should be grateful that too much insight into the deeper layers of the psyche has not rendered her powerless to offer practical help to a struggling world of parents and children.

Jessie Taft.

Child Study Department,
Children's Aid Society of Pennsylvania.

NOTES AND COMMENTS

Legislative Notes

The change in classification of the summaries of proposed and adopted laws has been made in order that they may be more readily referred to by subject matter as well as by states. The Department of Information and Statistics of the National Committee for Mental Hygiene maintains complete files of all bills and laws here summarized and will be glad to send copies of individual bills upon request.

The year 1929 gives indication of being an important year in legislation related directly to the mental-hygiene field. The legislatures of 43 states and 4 territories and the National Congress are in session during the year. Of these, 19 are scheduled to adjourn by the end of March, while Florida convenes April 4 and Georgia, June 26.

Administration and Finance

California

H. 144. To amend Section 1373 of the penal code, provides that the expense of sending a dependent accused of crime and suspected of insanity to a state hospital, of keeping him there, and of bringing him back, shall be borne in a manner similar to the expenses of insane persons not accused of crime.

H. 309. Provides for city and county boards of mental health. (Referred to Committee on Health and Quarantine.)

S. 103. Creates a commission to select a site for a state hospital for the insane. (Referred to Governmental Efficiency Committee.)

Indiana

S. 26. Permits state to levy charges for the treatment of insane persons against the patient's estate if there are no near relations. (Passed by both houses.)

S. 69. Provides for the appointment by the governor of a board of trustees of four members to govern the colony for feebleminded at Butlerville.

Kansas

H. 447. Would create the office of state probation officer, prescribing the duties thereof. This bill is a substitute for H. 161, which was killed, and differs from it only in the following respects: The

probation officer shall be appointed by the state board of administration from among the present employees of that board and shall receive no additional compensation other than traveling expenses when performing official duties. H. 161 provided that appointment be made by the governor and that the salary be $2,700 per annum and traveling expenses. This bill eliminates the $5,000 appropriation carried by H. 161. H. 161 provided that the judges of the juvenile courts of the state might call upon the probation officer for assistance in the handling and placement of any dependent, neglected, or delinquent child. The present bill provides for such assistance in the case of any child that may come before said courts.

Maine

S. 410. Provides for the licensing and regulating of private hospitals and private houses for the treatment of nervous and mental patients, and for voluntary, temporary, and permanent commitment to such hospitals and houses in accordance with the regulations that govern state hospitals.

Michigan

S. J. R. 6. Proposes amendment to the state constitution authorizing the state to borrow money to be used for the purpose of building hospitals and asylums for the insane and other state institutions.

Missouri

H. 401. See under "New Institutions and Clinics."

H. 555. (Same as S. 407.) Would create a department of mental disease under the supervision and management of the health supervisor and the six members of the board of managers of the state eleemosynary institutions, at least one member of which, besides the health supervisor, shall be a physician, with knowledge of the proper care and treatment of the insane. Among other duties the department shall appoint, at the request of the court in all cases where insanity becomes a court issue, a member or members of the medical staff of any state hospital to make such examination of the mental condition of the individual involved as he or they may think proper and necessary, and shall report in writing to the court. The report shall be available to counsel on both sides for their information and the examiners, when duly subpoenaed, shall appear and testify as witnesses. The department of mental diseases shall also examine or cause to be examined by members of the staff of any state hospital at least three times each year the inmates of the Missouri State Penitentiary and the Missouri Reformatory, and make report

thereof in writing to the commissioners of the department of penal institutions and the governor. Such inmates as are found by such examination to be insane shall be removed immediately by the commissioners of the department of penal institutions to the proper institutions provided by the state for such unfortunates.

Montana

H. 314. Would appropriate money for a house for the criminal insane, with living quarters for physicians, and so forth, at the Montana State Hospital for the Insane. (Reported favorably.)

New Hampshire

H. 173. Provides for the appropriation of $200,000 for the construction and equipment of a dormitory for disturbed male patients at the state hospital. (Referred to State Hospital Commission.)

Ohio

H. 46. Would repeal section that provides for the payment by the feebleminded for maintenance in state institutions. (Referred to Commission on Benevolent and Penal Institutions.)

S. 51. Makes an appropriation to the amount of $816,661.04 for the construction of an institution for the feebleminded to be known as the Apple Creek Institution.

Pennsylvania

S. 5. Authorizes and regulates the establishment and operation by counties of hospitals for the treatment of women afflicted with nervous diseases.

Texas

H. 270. Establishes state epileptic and tuberculosis hospitals for negroes. (Referred to Commission on Eleemosynary Institution.)

Certification of Qualified Psychiatrists

New York

H. 1160. (Same as S. 865.) Would amend the mental-hygiene law by creating, in the department of mental hygiene, a board of psychiatric examiners, to consist of the commissioner of mental hygiene, who shall be chairman, the commissioner of education, and the commissioner of health. This board shall determine the qualifications of psychiatrists to act in any criminal action or proceeding prosecuted by indictment, where the service of a qualified

psychiatrist is required, and shall certify thereto. A person found by the board to be so qualified shall be known as a certified psychiatrist. The following are the minimum qualifications for obtaining the certificate of the board, and the board may establish such further requirements from time to time as it may deem proper:

1. Applicant must be a physician duly licensed to practice in the state of New York and must have had at least five years experience in actual practice.

2. He must either (a) have had three years' experience since January 1, 1915, in the care and treatment of persons suffering from mental diseases, in an institution for the care of such persons and having accommodations for at least fifty patients, or (b) have devoted the five years immediately prior to filing his application for certification in a private practice confined wholly or substantially to the care and treatment of persons suffering from nervous and mental diseases.

Commitment

Colorado

H. 158. No child under the age of sixteen years shall be committed to the state hospital at Pueblo by any court.

Maine

S. 90. Provides for the admission to either of the state hospitals and the care and observation for not more than thirty days of all persons who, in the opinion of two registered physicians, are in need of such care. Provides, further, for a regular commitment if, after a period of fifteen days' observation, the superintendent believes it for the best interests of the patient.

Massachusetts

S. 221. Provides for temporary observation commitment and regular commitment to Federal hospitals for the insane.

The Criminal Insane

Montana

H. 314. See under "Administration and Finance".

Delinquents: Defective, Psychopathic, Maladjusted

California

H. 167. Provides for an institution for the confinement and care, training, and rehabilitation of defective delinquents and for the admission and commitment of such defective delinquents. Also

provides penalties for certain violations of the act. (Referred to Commission on Public Charities and Corrections.)

S. 783. Creates a commission to prepare and submit a report of juvenile delinquency, embodying a plan for the prevention of juvenile delinquency and for the care and training of pre-delinquent, psychopathic, and maladjusted children. (Referred to the Commission on Public Charities and Corrections.)

Illinois

S. 25. Provides for the segregation of mental defectives. For the purpose of this act "mental defective" means a person who has (a) a defect of intelligence or (b) a defect of affectivity or emotion or (c) a defect of will to such degree that he has criminal propensities and, while at large, is a menace to the person or properties of others. The provisions of this act would apply to the following classes of persons: (1) any suspected mental defective residing within any community in the state; (2) any child under seventeen years of age who is brought before a juvenile court and who is suspected by the court of being mentally defective; and (3) any inmate of a penitentiary, or any person applying for or released on parole, who is believed by the department of public welfare to be mentally defective.

Indiana

S. 36. Provides for the creation of a permanent state probation commission with jurisdiction over adult as well as juvenile cases.

Kansas

H. 310. Provides for complete mental and physical examinations of all persons committed to the state industrial farm for women, the industrial school for boys at Topeka, and the industrial school for girls at Beloit. Prescribes a thorough psychiatric examination by a competent psychiatrist provided by the state board of administration. Records are to be kept of all examinations and, when requested, court physicians, probation officers, and all others who have pertinent information concerning the inmate, shall furnish to the superintendent and examining physicians all such information. The board shall cause such measures to be taken for the correction of any physical or mental defects in any person examined as may be recommended by the physician making the examination and as said board may deem proper. (Referred to Commission on State Affairs.)

Massachusetts

S. 53. Provides for the appointment by the governor of "a special unpaid commission consisting of the commissioner of the department of public welfare, the commissioner of mental diseases, the deputy probate commissioner, and two other members" to investigate the laws relative to dependent, delinquent, and neglected children or children otherwise requiring special care. This commission is to report not later than December 1, 1929, and make any recommendations as to changes it deems necessary, together with drafts of legislation to carry such recommendations into effect. (Referred to Legal Affairs Commission.)

New York

H. 800. (Same as S. 733.) Amends Section 124, mental-hygiene law, by permitting the court of special sessions of New York City to order commitment to an institution for mental defectives of any mentally defective persons over sixteen years of age charged with misdemeanors. (Passed by house.)

Examination of Prisoners and of Certain Persons Accused of Crime

Missouri

H. 555. (Same as S. 407.) See under "Administration and Finance".

New York

H. 857. This bill, the second part of which is substantially the same as the Massachusetts "Briggs Law", would amend the mental-hygiene law by providing for a division for the examination of certain persons accused of crime, the head of which division would be an assistant commissioner appointed by the commissioner of mental hygiene. The bill, further, would amend the code of criminal procedure by providing for the examination, by the newly created division, of every person who "is indicted by a grand jury or is held to answer on a complaint or information charging capital offense, or . . . is indicted by a grand jury or is held to answer on a complaint or information for a crime, after having been previously indicted or so held for any other offense more than once, or after having been previously convicted of a felony", the examination being made "with a view of determining his mental condition and the existence of any mental disease or defect which may affect his criminal responsibility".

Epileptics

New York

S. 173. (Same as H. 309.) Amends article 7, mental-hygiene law, relative to Craig Colony as follows:

1. Craig Colony is now declared to be a body corporate.
2. Only epileptics "resident" in New York State may be admitted.
3. In addition to "the superintendent of the poor or the proper city poor law officer" petitioning for commitment, the following persons are also qualified: "any person with whom an alleged epileptic may reside or at whose home he may be, or the father or mother, husband or wife, brother or sister, or the child of any such person, or the nearest relative or friend available, or the committee of such person, or an officer of any well recognized charitable institution or home".
4. A candidate may not be examined for admission, under the terms of this section, if he is in confinement on a criminal charge or a defective delinquent.
5. Voluntary admission is made possible upon the written application of the epileptic person himself, or if he is a minor, on the written application of his parent or legal guardian.
6. Sections relating to the disposition of unclaimed property of discharged or deceased patients, and to the temporary custody of personal property of insane persons, are made effective for Craig Colony. (Passed by senate.)

Insanity Pleas in Criminal Cases

California

H. 768. Amends Section 1026 of the penal code by changing the order in which the plea of "not guilty by reason of insanity" may be tried. (Referred to Commission on Crime Problems.)

S. 207. Adds a new section, No. 1027, to the penal code, providing that when "a defendant pleads not guilty by reason of insanty, the court must select and appoint two alienists, and may select and appoint three alienists, from the medical staffs of the state hospitals, to examine the defendant and investigate his sanity". The alienists must perform examinations and testify whenever summoned, without compensation, their actual expenses only being paid by the county in which such action is pending. Any party to any criminal action may produce any other expert evidence it desires, as to the sanity of the defendant, but other expert witnesses shall be entitled only to the ordinary witness fees. Any alienists appointed by the court may be called by either party to the action

and will, in all cases, be subject to examination as to qualifications as an expert, and to cross-examination the same as in the case of any other witness.

Marriage and Divorce

California

H. 47. Amends Sections 92 and 139 of the civil code, adding a new section, No. 108, which makes insanity a cause for divorce. The insane spouse must have been duly committed to and confined in an insane hospital in California for five years immediately preceding action for divorce, and the incurability of the insanity must be testified to by three alienists appointed by the court, whose fees are payable by plaintiff. If it be proved "that the insanity complained of was caused or produced by an act or acts of the party seeking the relief, or as a consequence of the discharge of marital duties, such as childbirth, or as a consequence of change of life, it shall not be a ground for divorce". No person bringing such action, or who has obtained a divorce on such ground, is eligible to act as guardian of the person or estate of the insane spouse.

Maryland

H. 84. Makes hopeless insanity a ground for divorce *a vinculo matrimonii.*

Michigan

S. 146. Makes incurable insanity, with commitment to and confinement in an asylum for the insane for a period exceeding five years, grounds for divorce.

S. 347. Would authorize the guardian of an insane person to prosecute an action for divorce.

Nebraska

H. 435. Makes insanity that has existed for a period of five years and is incurable a ground for divorce, and provides for the guardianship *ad litem* of the defendant.

New York

H. 145. Amends Section 1147, adding a new section, No. 1142a, to civil-practice act, by adding to causes for divorce extreme and repeated cruelty, conviction of felony or infamous crime, insanity, physical incapacity, habitual intemperance, fraud, refusal to cohabit and desertion for three years, want of age, consent, and incestuous marriages. (Referred to Codes Committee.)

Oregon

H. 271. Would permit persons of unsound mind to obtain divorce through their guardians. (Referred to Commission on Revision of Laws.)

Mental Defectives

New York

S. 646. Would amend the mental-hygiene law in relation to the temporary and voluntary admission of mental defectives to institutions for the same as follows: A person received for temporary care shall not be detained for more than ten days if he, or any person in his behalf, shall make written request for release, unless the superintendent or physician in charge thereof shall deem such detention necessary, and shall so certify, with the approval of the commissioner, to a judge of a court of record, who may in his discretion forthwith issue an order committing such person to such institution for care, custody, and treatment. A mentally defective person may be received and retained in an institution for the care of such persons, upon a written application made therefor by him, if he be of full legal age, or by his parent or legal guardian if he be a minor, but he shall not be retained more than ten days after regular notice has been made of his desire to leave or of his guardian's intention to remove him. At any time during which such person is an inmate in such institution, any legally authorized person may apply to the court for his commitment, in which case the usual prescribed procedure will be followed. (Passed by senate.)

New Institutions and Clinics

California

H. 523. Provides for the establishment in southern California of a state hospital for the insane, appropriating $250,000 for the purpose.

H. 692. Establishes a colony for feebleminded persons.

Connecticut

H. 208. Appropriates $1,750,000 for the construction and equipment of a state hospital for the insane in Fairfield County, to be known as the Fairfield State Hospital. (Referred to the Humane Institutions Commission.)

Delaware

S. 29. Creates a psychiatric clinic at the state hospital for the insane. (Referred to Commission on Revised Statutes.)

S. 30. Authorizes establishment of a mental-hygiene clinic under the direction of the trustees of the state hospital for the insane. (Referred to Commission on Public Health.)

S. 31. Authorizes establishment of a psychiatric observation clinic at the state hospital for the insane. (Referred to Commission on Public Health.)

Maryland

S. 8. Creates and establishes a colored state training school to receive and train imbecilic, idiotic, and feebleminded colored persons, and authorizes the creation of a state debt of $100,000 for purchase of land and erection of buildings for same.

Minnesota

S. 420. Provides for the construction and maintenance of a psychopathic hospital at the state university and makes an appropriation of $260,000 therefor.

Missouri

H. 401. Provides for the issuing of bonds or the levying of a direct tax for the purchasing of land and erecting thereon a building or buildings to be used as a county hospital for feebleminded minors or minors afflicted with any form of insanity or mental deficiency in counties having a population of not less than 200,000 and not more than 750,000.

Montana

H. 314. See under "Administration and Finance".

New York

H. 784. Amends the correction law by making provision for a psychiatric clinic at Sing Sing Prison. Concerning this bill, Mr. E. R. Cass, General Secretary of the Prison Association of New York, says that it "definitely writes into the law the status of the psychiatric clinic at Sing Sing and prescribes its scope of activity. It further provides that all commitments to the state prison be made directly to Sing Sing Prison, and not, as at present, on the basis of judicial districts. Most prisoners in the state are committed directly to Sing Sing, which makes it a logical place for a receiving and distribution station. . . . It embraces classification on the basis of scientific study and knowledge and the prescribing of individual treatment".

Texas

H. 270. Establishes a state tuberculosis and epilepsy sanitarium for Negroes.

Utah

S. 51. Provides for the establishment of the Utah State Training School for the care and protection and treatment of feebleminded persons, and for a commission to locate same. The building is to be constructed by prisoners from the state prison. (Passed by senate.)

Washington

S. 84. Establishes an institution for the training, care, and custody of feebleminded persons in the western part of the state, to be known as the Western Washington Industrial School, and appropriates $200,000 for the purpose.

Special Classes for Retarded or Problem Children

New York

H. 544. (Same as S. 370.) Amending Sections 578 and 579a of the education law, removes the limitation of the size of classes for retarded children by striking out the words "three years or more" retarded, so that any retarded child may be admitted to such classes, and by placing the power of decision and establishment of such classes "under rules to be established by the state education department". This bill is highly approved by the State Committee on Mental Hygiene of the State Charities Aid Association. (Reported favorably out of the senate committee on education.)

Veterans

A bill providing for (1) the appointment of guardians of mentally incompetent veterans of the United States military and naval forces and of minor children of incompetent, disabled, or deceased veterans and of mentally incompetent dependents of said persons, (2) the commitment of mentally incompetent veterans, and (3) uniform laws with reference thereto, has been proposed in the legislatures of the following states: Connecticut, Iowa, Kansas, Maine, Maryland, Massachusetts, and Missouri.

Miscellaneous

Iowa

H. 163. Provides for the waiving of a jury trial in cases of appeal from a commitment order in insanity cases. (Referred to the Judiciary Committee, which reported that it should be indefinitely postponed.)

Kansas

H. 803. Would provide for a lunacy commission in each county of the commonwealth in insanity commitment cases.

S. 172. Provides for reëxamination at any time of the mental and physical condition of operators of motor vehicles, to determine their fitness to operate such vehicles.

S. 186. Makes accessible to probation officers reports relative to the mental condition of certain persons held for trial. (Referred to Legal Affairs Commission.)

Michigan

H. 78. Provides that persons certified insane by physicians may be detained five days without court order.

Minnesota

H. 339. (Same as S. B. 225.) Makes it a felony to abduct, entice, or carry away any feebleminded or epileptic person committed to the guardianship of the state board of control from any institution or place.

Missouri

S. 407. Would create a department of mental diseases.

New York

H. 174. (Same as S. B. 90.) Amends subdivision 7, section 2, of mental-hygiene law by defining "resident" to be a person who has lived in the state at least one year "continuously". (Passed by both houses and approved by governor.)

H. 757. Adds new section, 72a, to mental-hygiene law, making it mandatory upon the court to assign counsel to a person in proceedings to determine question of insanity when that person is not provided with counsel.

H. 783. Amends section 8, correction law, providing for a third assistant commissioner of correction who shall be a qualified psychiatrist of not less than five years experience "in the practice of nervous and mental diseases". Concerning this bill, Mr. E. R.

Cass, General Secretary of the Prison Association of New York, says: It "has the approval of Dr. R. F. C. Kieb, of the state department of correction, and is approved by the crime commission, the State Committee on Mental Hygiene of the State Charities Aid Association, and the Prison Association of New York. . . . It is Dr. Kieb's plan to use this additional staff member to work out, under his direction, the psychiatric program of the state department of correction and to take care of psychiatric needs arising in the various prisons and in county jails and penitentiaries. While it is true that this is considerable work for one psychiatrist, nevertheless, it is a beginning, and at the start attention will be directed particularly to special needs. This should not conflict with the psychiatric clinic at Sing Sing, but rather tie up with it."

S. 837. Provides that fees for commissioners in lunacy shall be fixed by the court.

Pennsylvania

H. 227. Amends the act providing for the protection of insane, feebleminded, and epileptic persons by extending the privilege of having a guardian appointed, so that it includes persons "having real or personal estate" in the state, as well as legal residents thereof.

S. 39. Permits courts of record to receive the sworn statement of the superintendent, if he is a duly licensed physician, or of the physician in charge of any hospital, home, asylum, or other such institution as prima facie evidence of the mental condition of any person confined in such an institution.

United States

H. 16436. Provides for repatriation of insane American citizens in Canadian asylums.

S. 5602. Provides for the transfer of American citizens adjudged insane in foreign countries to St. Elizabeths Hospital, in case the individual's legal residence in one of the states, territories, or possessions of the United States cannot be established. In case such residence is established after patient's admission to St. Elizabeths, the superintendent of that hospital is authorized to transfer him to the place of his legal residence. Necessary funds for this purpose are authorized by the bill.

A Psychiatric Institute of Research Established in Paris

The Paris correspondent of *The Journal of the American Medical Association* announces the establishment of the Institut de recherches de psychiatrie in connection with the Ecole des hautes etudes. It has

been installed in the Hopital Henri-Rousselle, where there is already a center of mental prophylaxis directed by Dr. Toulouse. "The institute will comprise laboratories and regular lecture courses. The first series of lectures will be devoted to the study of mental fatigue and the diminution of the power of attention, which lie at the basis of many psychopathic manifestations. The demonstrations will be combined with clinical, physiologic, and chemical researches. The next series of lectures will be given by Dr. Roubinovitch, and will deal with 'The Perverse Tendencies in Infantile Psychiatry'."

The Belgian League of Mental Hygiene

The Belgian correspondent of *The Journal of the American Medical Association* gives the following account of the Belgian League of Mental Hygiene:

"The Ligue d'hygiene mentale was created in 1922, and has a number of chapters in the provinces. The dispensaries of the league collaborate not only with the psychopathic hospital, but also with the judicial authorities. They are the center of the supervisional care given to mental patients, since these must not be left to charity or to the care of themselves. The supervision must, of course, be of a scientific professional nature. The problem of mental hygiene is vast and touches many different fields, such as pedagogy and professional instruction. The dispensary attends to many details that occasion considerable loss of time to the uninitiated; for instance, inquiries into the family and social environment. This makes it possible to give to the hospital physician the assurance that the patient he is planning to dismiss will find a favorable environment on his return home. The physician may require the patient to present himself at the dispensary at definite intervals for a certain period. At first, this measure meets with some defiance on the part of the patient, but once confidence is restored, the patients not only visit the dispensary, but sometimes bring in others.

"The dispensary did not begin to give aid to children until November, 1926. Such assistance involves both medical and social problems. Thus three periods are to be considered: 1. The pre-school age, a period of adaptation to life, which affords an opportunity to intervene from a prophylactic point of view; one observes few mental symptoms in these children (except in the markedly abnormal types), but one does observe many physical signs. 2. The school age (the period of adaptation to school, and the phase also of the development of the intelligence). The disorders that one is called on to look after during this period are already completely developed. 3. The post-school age

(the period of social adaptation, and the period of delinquency). The children are brought by their parents or by the nurses of social-welfare organizations and the schools, or are sent by the judge of the juvenile court. One of the great advantages of the system is that often children may be allowed to remain in the environment of the family, which has both a moral and a material value, whereas, except for the aid of the dispensary, hospitalization would be necessary. The rôle of the dispensary of mental hygiene is important likewise in the treatment of delinquents. It is the duty of the psychiatrist to restore his patients to society, and this can be accomplished by his collaboration with the dispensaries of mental hygiene."

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M. THÉRÈSE DE BERMINGHAM

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MENTAL HYGIENE

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DO ALIENISTS DISAGREE?

IS THE INSANITY PLEA BUNK?

CLARA R. CUSHMAN

Attorney at Law, Santa Ana, California

"INSANITY'S bunk—and alienists sell opinions. If they don't, why can't they agree?"

Mrs. Estelle Lawton Lindsay, of the *Los Angeles Express*, in commenting on the trial of William Edward Hickman, kidnaper and murderer, thus purported to quote a business man, a man of keen common sense.

"This much stands out from the Hickman trial", Mrs. Lindsay continues. "People are weary to death of insanity as a defense in murder cases. . . . People simply do not believe that Hickman is anything but sane, calmly and permanently sane, and they will continue to believe that, regardless of how many insane ancestors the young men who are defending this icy outlaw may produce. They believe that he is sane and that the effort to prove him otherwise is a ruse to save a neck that is overdue to be cracked."

Mrs. Lindsay is an "expert" on matrimonial problems, conducting a column in the *Los Angeles Express* called *The Log of the Good Ship Marriage.* It seems to be a rule of all newspapers never to publish any article on a psychopathic murder case by a psychiatrist or a bona fide psychologist. But however little Mrs. Lindsay may be qualified to pass on this youth's mental state, she is at least correct in her interpretation of the mood of the people, which holds that because one alienist is testifying on one side and another alienist

on the other, the alienist is selling his opinion—at least, the alienist for the defense. "For if not, why don't they agree?"

Agree on what? The alienists themselves seem not to have thought this out clearly. For what purpose are psychiatrists summoned in these cases? Bear in mind, it is the sensational murder case now under consideration, not the case in which the mental trouble of the accused is so obvious that the defendant is not brought to trial, but a lunacy commission is appointed. It is the border-line case only that is responsible for the distrust of the alienist.

Is the psychiatrist in the courtroom to ascertain the mental condition of the defendant, to make a diagnosis? Not at all. Were that the issue, as it is on a lunacy commission or in the clinic and laboratory, there would be no essential disagreement. But the alienist is not there for that. That is merely incidental and of interest only to himself and his fellow psychiatrists. He is there to give an opinion, not upon a medical question, but upon a metaphysical question, a question grounded in the realm of mysticism. This metaphysical question, the law, still floundering in the mire of precedent accumulated before anything was known of the mechanics of human behavior, still holds to be the crucial test in a criminal trial—namely, has the accused sinned? If so, did he realize that he was sinning? For if he realized it, he ought to be punished.

Now what relation has this question to psychiatry? Of course the law does not use these Mosaic terms formally any more. But the spirit of mysticism still remains. The psychiatrist is summoned to give an expert(?) opinion as to whether, if the accused committed the act, he did so with the knowledge that he was doing wrong. Did he have sufficient mental capacity to know that the act was wrong? If he did, the law (not the psychiatrist) declares him sane. If he did not, the law declares him insane. For the law does not consult the expert as to what insanity is; the law makes a definition of its own to which the expert must adhere. Not so long ago priests were called on to answer these questions regarding "sin". Modern (so-called) criminal law has retained the priestly type of question, but has changed the type of person summoned to answer it. The scientist is trying to be

the priest. It would have been wiser to have left it with theology perhaps, for at least the theologian would take it seriously, while the medical expert knows that he is being placed in a false position. What wonder that when experts begin to testify, the jury feel that they may begin to drowse? And they do so, while the experts are made to look like pompous fools, forced as they are to attempt to answer professionally a question that has no place in their profession, a question that, lying as it does in the field of emotions and prejudices, they are no more fit to answer authoritatively than are other men—namely, the question of moral responsibility and of "free will". This is the question that they are forced by the law to dispute over, not their scientific findings regarding the mental condition of the prisoner at the bar, who, professionally speaking, is not a good man who ought to be saved or a bad man who ought to be punished, but in all probability a man from whom, both the experts for the prosecution and the experts for the defense earnestly agree, society should be protected.

A concrete case will illustrate the situation. The defendant was accused of a bank hold-up, and his attorney entered a plea of insanity. He was compelled to call the mental condition of the defendant "insanity", although he believed the youth to be feebleminded. The law does not recognize such terms as "moron", "imbecile", or "idiot". Five medical experts testified, two for the prosecution and two for the dedefense, while a fifth was summoned by the judge, in order that the jury might have the benefit of an unbiased opinion. This fifth witness was Dr. Edward Huntington Williams, of Los Angeles, a psychiatrist and criminologist of national reputation and the author of a number of books. All these five men examined the defendant and testified practically to the same facts. They affirmed that the defendant, twenty-three years old, showed every evidence of having suffered since childhood from a disease that affected the pituitary gland and that had retarded his mental development, just as it had dwarfed him physically. They affirmed that the youth was a moron. They fixed his mental age as between eight and twelve or fourteen years.

"Now, Doctor", finally would come the crucial question,

"in your opinion was the defendant, at the time he committed this crime, of sufficient mental capacity to appreciate the nature and quality of his act and to know that his act was wrong?"

"Yes", replied the two experts for the prosecution.

"No", replied the two experts for the defense.

"Yes", replied Dr. Williams.

The jury agreed with Dr. Williams and the experts for the prosecution, and this youth is now in San Quentin Penitentiary. For as Dr. Williams himself, and his coadjutor, Dr. Ernest Hoag, declare in their book, *Crime, Abnormal Minds, and the Law*,[1] "most of our courts permit us to hang children of seven years, for no matter what age a man may be, if his mind is that of a child, *he is a child* as far as responsibility goes".

And yet Dr. Williams, although believing that this young man had the mind of a child, testified for the prosecution. He was under oath and believed that this child knew it was wrong to try to rob a bank. And he said so. Conscientious? Assuredly.

Drs. Williams and Hoag have also this to say:

> "Now the knowledge of right and wrong is no real test of responsibility; what is a test is the ability to *act* on such knowledge. Even young children possess the knowledge of right and wrong, but no reasonable person expects them to always act responsibly. Animals possess such knowledge to some degree, at least by training. The feebleminded, except the lowest of them, all have some knowledge of right and wrong, but in a true sense they do not possess such knowledge because moral responsibility is based on judgment; and judgment in the feebleminded is not much developed. Accordingly the feebleminded cannot be expected to use judgment in respect to moral acts. As a matter of fact, psychologists now recognize that the moral and ethical sense is not much developed until after twelve years of age, although no one denies that children from a very early age possess a theoretical knowledge of right and wrong. The use of the term 'right and wrong' in a legal sense is an absolute misnomer. The legal test is, therefore, absurd on the face of it, because it does not take into consideration the inability to act on a theoretical knowledge of right and wrong. It dates back to times when the mechanisms of human behavior were little understood. . . . . No court would pass upon an obscure case of bodily ailment; yet courts every day do pass judgment without hesitation upon far greater questions of mental disorder and responsibility."

[1] Indianapolis: Bobbs-Merrill Company, 1923.

How does this quotation apply to Dr. Williams' testimony in the case cited above? It proves his consistency and explains his position. He believes that the law is antiquated, yet that as long as it is the law, it should be upheld, and he answers truthfully and logically that he believes this youth knew that his overt act was wrong; as for the rest, he leaves the law to take its course.

However, other psychiatrists have another and equally sincere attitude toward the courtroom tests of insanity. Dr. William A. White, of Washington, D. C., authority on mental and nervous diseases and on the legal aspects of psychiatry and an expert witness for the defense in the Loeb-Leopold case, interprets his duty as witness under present conditions not so much in accordance with the letter as the spirit of truth. He declares:

> "However possible it may have been at one time for the medical and legal professions to come together on these tests and find in them a basis of common understanding, that day has long since passed, at least from the standpoint of the specialist in mental medicine. The standpoint from which he approaches the problem of human behavior no longer makes it possible for him to be dogmatic and categorical in his replies to the question of the lawyers on these points. . . . . The language of the law, while it might have been all right a hundred or two years ago, is no longer usable by the present-day psychiatrist who finds himself quite unequal to thinking in such terms and much less able to use them exclusively, as he is required to on the witness stand, for the expression of his thoughts. . . . . Father Schmidt [citing a notorious case in which the defendant was found sane and executed] when he murdered Annie Aumuller, may have possessed a knowledge of right and wrong in the sense that he knew it was against the law of the land to commit murder, as indicated by the fact that he tried to cover up the evidences of his act, but nevertheless at the time he drew the knife across her throat, he thought he was carrying out the command of God, he knew that he was doing right."[1]

Any number of cases might be cited, any number of textbooks on psychiatry quoted as further evidence of the professional harmony existing between alienists testifying at these trials. In Los Angeles alone, to mention a few, there is the Harry New case, when alienists on both sides, five in all, agreed that the defendant, New, was a moron, with intelligence permanently arrested at about the eleven-year level.

[1] *Insanity and the Criminal Law,* by William A. White, M.D. New York: The Macmillan Company, 1923. pp. 103 *et seq.*

Yet the defendant was convicted. Oxnam, De Witt, Bundy, Louis Fortin, Harris, the Negro, all murderers who have been recently hanged in California were declared to be mental defectives by every examining psychiatrist. Yet where insanity was plead, the whole situation changed, and the same alienists were testifying heatedly on both sides, disputing over—what? Responsibility, determinism, "free will", right, wrong, punishment—abstractions all, upon which they may render religious and ethical opinions, but in no circumstance a professional opinion. Such is the impasse into which the law has driven the medical expert. What, then, should be de-bunked? The law or the medical profession? Why has the medical expert been ridiculed and censured, and not the law?

The subject may be approached, and has, in many different ways. For a roughly outlined layman's article, such as this, it seems well to emphasize two points:

First, there is the conviction on the part of almost every man that he can tell an insane person when he sees one; that if a person is "calm" and "intelligent", he is indisputably sane. These words, "calm" and "intelligent", appear over and over again in the newspaper accounts of the kind of trial under discussion. The writer has accumulated an interesting collection of such newspaper comment and fallacious reasoning. Such reasoning is not confined to the average observer, but is shared with the so-called educators of popular opinion. There is Chester Rowell, for instance, who, not so long ago, in his syndicated column commented upon the fact that certain convicts in Folsom Prison who had engineered a prison break were about to plead insanity.

"They were, to be sure, sane enough", he argues, "to plan and lead the attempted outbreak, and dominant enough personalities to overawe their unwilling comrades, and they were clear-headed enough, when they saw they were beaten, to surrender and bargain for terms. These are all the marks, not merely of sanity, but of unusual intelligence and capacity."

Now Mr. Rowell's opinions and decisive statements are accepted with respect by thousands of readers of the daily newspapers. Yet here he makes a positive assertion upon a subject of which obviously he has no knowledge. Any quali-

fied alienist would have instructed Mr. Rowell, had he taken the trouble to inquire, that mental capacity, intelligence, and ability to carry out a preconceived plan are not conclusive proofs of a sound mind. And for Mr. Rowell to state in all seriousness that an organized jail break marks the perpetrator *ipso facto* as sane and having an extraordinary I.Q.—well, we need make no comment, for that statement is aside from our point, which is that a man of Mr. Rowell's attainments believes that he needs no expert knowledge to diagnose a case of insanity, and that insanity is a question of intelligence and mental capacity.

This statement is fallacious even when applied to the legal test of insanity, the "right-and-wrong test". Many paranoiacs have intelligence and mental capacity. So have most schizophrenics. Drs. Singer and Krohn, who testified for the prosecution in the Loeb-Leopold trial, stated, on page 57 and following of their book, *Insanity and the Law*:[1] "The intelligence of schizophrenic persons is usually good and is often above the average. Indeed, it seems probable that high-grade intelligence is necessary for the development of this mode of reaction." Further, in speaking of the deterioration that leads to these abnormal mental conditions, the authors write: "First, it should be said that the intellectual mechanism remains undamaged, though this is not always easy of demonstration."

Not to become too laboriously technical, then, it may be stated, with authorities in agreement, that the emotions bear a far greater part in the determination of one's mental state than does the intellect. But the "hard-boiled business man" previously referred to, and the intelligentsia as typified by Mr. Rowell, see the defendant sitting "calmly" and hear of the defendant acting "intelligently" and, forsooth, he is sane, and any expert who declares otherwise is either crooked or crazy himself or both. They are as sure of their infallibility on this point as were their progenitors who knew that the sun traveled round the earth because they saw it with their own eyes, and who heaped scorn and ridicule on the experts of their time.

1 *Insanity and the Law*, by H. Douglas Singer, M.D., and William O. Krohn, M.D. Philadelphia: P. Blakiston's Son, 1924.

But there is another and more elemental reason for the unpopularity of the medical expert. The alienist testifying for the defense stands for the red rag of juridical change. The people charge it in instinctive fury, as they have always done. Gradually, at a creeping pace to be sure, but steadily, the law is wresting from them a privilege that they have always deemed a right, an important source of animal pleasure—the vicarious torture of the social outcast. The people are being divested of a once universal license, the license to give public vent to their baser emotions, their hate and lust for revenge, and yet retain their self-respect. The gradual process of this divestment is interesting to trace.

There was a time when, with pomp and circumstance, even inanimate objects were often punished. A cart wheel that had run over a man, for example, was ceremoniously destroyed in the name of the law. With the same high-minded purpose and with great dignity and formality, distinguished gentlemen in pretentious robes tried dogs or cats, and meted out due torture and punishment to such creatures, in accordance with their best and most pious judgment, while the best citizens of the time enjoyed the spectacle because "justice was being vindicated". Nor did children escape their zeal. Children were hanged, imprisoned in foul dungeons, and sent into exile; their tongues were torn out, their eyes rendered sightless. Indeed it is only within our own memory that special acts have been passed to exempt them from the rigors of the law. As for the insane, it is only comparatively recently that the defense of insanity has been admissible. Instead of mitigating punishment, a diseased mental condition often augmented it in the past, as the good people of a few hundred years ago were convinced that such unfortunates were possessed of the devil and should be crucified, boiled in oil, burned at the stake, quartered, stretched on the rack, all in the name of righteousness and justice and for the greater glory of God. Gradually, as the centuries passed, a few leaders here and there would come to view the aspect of crime and wrongdoing in a different light, and would attempt to incorporate a shade of enlightenment into the welter of ignorance and lust for revenge. They came to see the absurdity of wreaking official vengeance on a tree trunk or a chair; though even to this day

we see man returning to this infantile reaction when in a fit of rage he smashes the furniture against which perchance he has stubbed a toe. No longer are dogs and pigs tried and punished in formal courts; the impulse of the individual lord and master to "kick the cat" may still survive, but his childish atavism and sadistic tendency is no longer reflected in the law of the land. Any number of men and women are still in favor of hanging and torturing children for their misdeeds. Indeed, children are still hanged in some cases and punished by various devices with the full sanction of the law, for the law cannot move much faster than the people wills. But the theory is gradually taking a firm hold that a child is not a responsible creature and therefore should not be an object of punishment, and the child criminal is now handled through juvenile departments whose object is to protect the community and rehabilitate the youthful offender. The child has been segregated as not a proper object for the vengeance of the crowd.

Upon the same theory the law has excepted the adult insane from its magisterial vengeance. It declares that an insane person cannot be "guilty". Jurists, advanced for their time, made this declaration many years ago. "But what", was the question confronting them, the question propounded by the infuriated crowd denied their victim, "what *is* insanity? This criminal is not shrieking and raving and tearing his hair. How dare the law let him escape by calling him a lunatic! Death to him! Give us our hanging and our holiday!"

Bunglingly, out of the medieval fog of metaphysics and superstition, the advanced thinkers of their day tried to concoct a reasonable answer, a rule and principle that would apply to every case. It was not easy. A dog or a cat, a cart wheel or a tree trunk, can be identified and segregated. So can a minor for whom the law may fix an arbitrary age. But what should be the criterion for distinguishing an insane person from a sane person? What the dividing line?

The courts chewed over this problem for many years. The first definite test applied was the "wild-beast test". It flourished as late as 1723, when Mr. Justice Tracy said: "It is not every kind of frantic humor, or something unaccountable in a man's actions, that points him out to be such a mad-

man as is exempted from punishment; it must be a man totally deprived of his understanding and memory, and doth not know what he is doing, no more than an infant, than a brute or wild beast; such a one is never the object of punishment."

No statistics will ever reveal how many persons of "frantic humor" and "unaccountable" actions were executed during the centuries when this doctrine prevailed. Then the legal conscience became once more active. The "wild-beast test" seemed extreme, and in 1800, Mr. Erskine, in a brilliant and eloquent defense, secured the acquittal of Hadfield for shooting at the king in Drury Lane Theater, on the ground that, being the victim of fixed insane delusions which caused him to commit the crime, the defendant was not responsible. From this time on the "knowledge test" crept in, the "right-and-wrong test". But Chief Justice Mansfield put a check on insidious advances, such as Lord Erskine's eloquence was in danger of fostering, by ruling in 1812 that "if such person were capable in other respects of distinguishing right from wrong, there was no excuse for any act of atrocity which he might commit as the result of delusion". And no statistics will reveal the number of executions that continued to occur under this "advanced" ruling. Then in 1843, in another revolutionary trial, once again the number of victims was cut down. In that year occurred the trial of McNaughton for shooting Drummond to death, whom he mistook for Sir Robert Peel. At the trial it was shown that McNaughton harbored the delusion that Sir Robert had been persecuting him, hounding him in an effort to ruin his reputation. In all other respects the defendant was apparently normal. He was acquitted. So enraged were the people that the House of Lords requested from the trial judges a statement in answer to a questionnaire, explaining in full the rules and principles whereby such a verdict could have become possible. And in their reply the trial judges formulated and established as a guide the principle that governs the courts of England and the United States to this day—namely, that to establish a defense on the ground of insanity, it must be clearly proved that at the time of committing the act, the accused was laboring under such a defect of reason from disease of the mind as not to know the nature and quality of the act he was doing, or if

he did know it, that he did not know he was doing what was wrong.[1]

So, in excluding from the ranks of the condemned offenders who were suffering from a delusion that caused the overt act, Mr. Erskine's doctrine was reaffirmed. This was almost one hundred years ago, and since then the whole subject of psychology and psychiatry has developed from theory and specucation into a science. But the law has remained fixed.

And now revolutionary changes are brewing; psychiatrists and criminologists are proposing changes which, when echoes of them reach the public, are met with the same violent opposition that marked every advance in the past. For the modern psychiatrist and criminologist are advocating completing at one sweep the job their predecessors have been merely toying with. They would take from society's vengeance the remaining fraction of social outcasts and handle them in accordance with modern scientific methods. While the tendency has been to permit fewer and fewer scapegoats, modern science asks, Why have scapegoats at all? What real difference does it make to an offender, save in case of capital punishment, whether he is labeled "wicked" and "criminal" and punished with imprisonment in a building called a penitentiary, or labeled "good", but "insane" and corrected by confinement in a building called a hospital? In both cases he is deprived of his liberty. And what difference does it make to society? Why split legal hairs to settle this mystical question of man's goodness or badness, to pin a label on an offender, when the practical consequences are to such a degree the same, and are tending more and more to become identical? Why not make the matter of segregation the focus of the trial instead of the matter of punishment? Instead of the court bringing all the lumbering force of its expensive, top-heavy machinery to bear on the question of guilt or innocence—a procedure that, taking into consideration the frailties of all mankind, including judges and juries, is enough to make the cosmos smile—instead of thus trying to imitate Omnipotent wisdom, why not take out the old machinery and install new? Why not center the legal process around these simple, practical, yet vital questions: Is the act complained

[1] Singer and Krohn, *op. cit.*, p. 288.

of dangerous or harmful to society? Did the accused do the act? If he did, what shall be done with him in order best to conserve the individual and protect society? In short, why not treat the adult criminal as we treat inanimate objects, animals, minors, and the obviously insane—protect society, and let it go at that?

Why not? Because such sweeping reform would not be tolerated, depriving us, as it would, of the last crumbling remains of our once universal privilege—that of indulging our lust for revenge and hate. There would be nothing left then for us to punish, except perhaps our children and our dogs. We would be in peril of becoming Christians in reality, of feeling sympathy for all mankind, and gradually of understanding human motives; while at present to feel sympathy for and harbor a desire to understand abnormal behavior is considered a mark of degeneracy, a perversion that should itself be punished. We reject such reforms with all the pious claptrap and high-sounding shibboleths with which we always clothe our unlovely instincts to make them respectable. "Justice must be vindicated", we chant. "Society must be protected." "We must make examples for others." But as the occasion becomes special and our excitement is heightened, our phrases lose their dignity. Then it is, "I'd like to hang him with my own hands!" "Hanging's too good for such as he!" "I hope he'll swing for it!" "Death to him!" "Kill him!" "Burn him!" Or if a little squeamish about doing the job ourselves, we hire an executioner. Should an individual here and there suggest anything approaching a reform in this ancient, well-loved procedure, we label him a "long-haired reformer", unfit for the society of real "he men" with "red blood in their veins". Or if the dissenter is an expert expressing his findings and tracing out the mental or emotional bypaths that led the criminal to this pass, such expert is "crooked", "selling his opinions" "to save a neck that is overdue to be cracked".

It is such a short time, after all, since a hanging, quartering, stretching, or mutilating was an occasion for a public festival which all the righteous attended. And now the sight of an authorized killing is open only to a select few, has become a form of special privilege. Tickets are issued only to

men with a drag. Women are not admitted, "he men" always being tender protectors of the sensibilities of females except when they believe one of them needs hanging. Only about two hundred males, judiciously weeded out of the thousands of applicants, were honored with tickets to the William Edward Hickman function in San Quentin. All the rest of the eager public were compelled to look to the newspapers to furnish them with a kind of second-hand thrill. It is the newspapers' job to make their accounts so realistic that their voracious readers may feel as if they were actually present and taking part in the event. This they do right heartily.

Students of psychiatry, criminology, and the science of human behavior are with increasing insistence demanding something different. Jurists here and there are beginning to study these subjects with a view to applying their knowledge to the human problems with which they are confronted. It is a dangerous time for the pleasure of the mob, and this they know. And at every fresh assault of science and enlightenment upon their ancient privilege, their right to enjoy a killing without feeling any sense of sin, they meet the attack with rage and ridicule. The expert alienist, in league to rob them of their festivals of reading, if not of seeing, is naturally a highly unpopular personage. To quote again from Mrs. Lindsay's correct interpretation of the popular spirit:

> "Of course nobody can tell how a jury will decide, but it's easy to realize that people who can think even a little are disgusted with the efforts made by attorneys to get people into insane asylums when the public feels, without analyzing its sentiments, that a few hangings would do more to reduce the murder rate than anything that psychologists can devise."

"The public feels without analyzing its sentiments", writes this lady, and with this statement every psychiatrist will agree. The psychiatrist and psychologist analyze those sentiments. They are not pretty.

MIND—MAN'S MOST DISTINCTIVE ORGAN *

WILLIAM A. WHITE, M.D.

Superintendent, St. Elizabeths Hospital, Washington, D. C.

IN the first chapter of *Dombey and Son,* Dickens portrays the two weightiest and most essential events in man's short span of life—namely, birth and death. While the baby, Paul, was carefully tucked up in a little basket bedstead in front of the fire, the mother, Fanny, "drifted out upon the dark and unknown sea that rolls round all the world". The reason ascribed for Fanny's exitus was her unwillingness or inability to make an effort. As the sister-in-law says to the husband, "An effort is necessary. That's all. * * * I have no doubt she'll make it. Knowing it to be required of her, as a duty, of course she'll make it. * * * If you have any reliance on my experience, Paul, you may rest assured that there is nothing wanting but an effort on Fanny's part. And that effort she must be encouraged, and really, if necessary, urged to make."

Effort, strain, energy. In such terms only are we able to feel ourselves into the processes of life and to recreate in our imagination the course of evolution that fate has decreed it should follow. Whether Fanny could have made the effort expected of her, and if she had, whether she would have lived, are for all the Fannies questions that remain unanswered. The feeling, when we have pursued one course of action, that we might have pursued another is no proof that we could have. Do we live or are we lived by a host of controlling and mostly unknown forces? This raises the whole question of freedom versus determinism. I can only answer by saying that the more profoundly we inquire into the antecedents of any given act or acts, the more surely do we find adequate explanations for such acts in terms to which, from the point of view of present-day scientific standards,

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we may properly apply the term cause. If this were not so in the mental realm, as it is in all others, then so far as I can see any inquiry would be a more or less useless and meaningless occupation.

This effort, strain, tendency, drive, call it what you will, is what we know as function, for we can think of function only in terms of effort. In the physiological realm we are accustomed to see this function stored, sluiced, channeled, and distributed to the ultimate consumer by means of a series of structures which exist for that purpose—blood vessels; lymphatics and their contents, blood and lymph, as carriers; nerves and nerve fibers; and many others. With the mind it seems different, for here are no tangible parts to deal with, but only what appears to be nascent function. Many would insist that the brain is the physical organ of which the mind is the function. While I am willing to admit that the mind manifests itself through and by means of the brain, I do not think such a statement—namely, that it is the organ of the mind in an exclusive sense—can be true. The heart may go on beating when removed from the body, but we have no evidence that a brain removed from the body could be the seat of mental functions, more particularly of consciousness.

Approach the problem as we will, from the standpoint of what we know or from the standpoint of what we do not know, the only practical thing to do is to consider the mind as such, irrespective of its relation to any structure, or structures, as a legitimate subject of inquiry. There are those who insist that mind and cerebral cortex should not be separated, but that all mental phenomena should be translated into the language of neurology. This to my mind is not only a bootless procedure, but an altogether foolish one. While I have every sympathy with all attempts to bring about a correlation between mind function and cortex function, I see no reason why we should stand idly by waiting for the day of its consummation before we proceed with our investigation of the mind. The outlining of the natural history of a function is as worthy an enterprise as recording the natural history of a structure, and in these days, when modern physics seems even to be repudiating matter, the distinction seems to be one that presents few real differences. Talking about

mind in terms of nerve cells does not help us understand it. It only translates the language of psychology into that of neurology, and to my mind with no gain. To this linguistic device, which seems to me only another way of retaining the cerebral mythology of the last century, Professor Meyer has given the very expressive designation of "neurologizing tautology". What we may do if we wish—and what I do, as a matter of fact—is to consider by analogy the mind as an organ, in the sense of any other organ—namely, that it has something to do; in which case, by further analogy, its content would be its structure and its processes its functions. Considered in this way, I am justified in my title: *Mind—Man's Most Distinctive Organ.*

What are some of the distinctive characteristics, some of the outstanding facts of structure and function, of this organ of the mind that grow out of this way of considering it and that have importance and significance for medicine? Naturally I can only touch upon a certain few points lightly.

In the first place, the organism as a whole, to use the modern biological term of expression, is like a many-faced crystal. Any one of its many facets may be examined to the exclusion of the others, and in that facet the examiner will see his own particular interests reflected. The anatomist will see structure; the chemist, molecules, atoms, radicles, valencies; the physiologist, organ functions; the drug therapist, pharmaco-dynamic reactions; the surgeon, the answer to his question, Shall I operate? The psychologist will see mind, and the anthropologist will see a functioning unit in a large racial scheme with customs, traditions, and a culture. But please note that the fact that one may be interested in only one particular facet does not mean that the other facets do not exist. Quite the contrary, and it is my main thesis that the neglect of the psychological facet has reached a stage, not only in medicine, but in the social sciences generally, that calls for prompt and decisive recognition and appropriate action if we are to be saved from the serious consequences of our failure.

The reason for this failure seems to me to reside, in part at least, in the exceedingly simplistic, not to say naïve, way in which the mind is usually thought of, and consequently

the almost complete helplessness the average person feels if called upon to observe and describe a person's mental condition. This type of reaction is often seen on the witness stand. Why people should have this sort of attitude toward the mind, which in the next breath they will declare their most valued possession, is not easy to see, and I will not discuss it further. The fact is, however, as is implied in my analogy to the crystal, not only that the mind is as old as the body, that every state of the organism has a mental as well as a somatic aspect, but that the mind is quite as complex, if not more so, than the body, and that it has embedded in its structure, just as has the body, the evidences of its historic past.

We have been familiar with such facts as these in every other realm than that of mind for so long that it seems it should be easy to accept them in this realm when attention is called to them, but experience has proved that it is not. However, a few analogies and parallels will help. In the field of neuro-anatomy, we have for some time recognized old and new parts of certain organs. Thus we speak of the paleo- and the neo-cerebellum, the paleo- and neo-striatum, the paleo- and neo-thalamus, and the archi- and neo-pallium. It is not to be supposed that the newer structures have taken the place of the older ones; they have merely supplemented them, and the older ones continue to function under the newer arrangements. For example, I saw a patient a few weeks ago with incipient signs of paralysis agitans. There was a slight tremor in one hand. When, however, this patient was asked to walk across the room, the whole arm was kept close to the side and did not swing as did the other. In other words, he had lost a component of what is normally left over to us of our quadrupedal gait. Surely that is not difficult to see or to understand in the light of the pathology of this affliction. Why should it be more difficult to understand, when a patient tells you she is afraid to hate any one, for, when she does, something terrible happens to him, that she is using a method of thinking common to both child and savage, based upon the idea that events can be brought to pass by thinking them; or that our common term "fourscore" contains within itself

the remnants of that historical past when savages counted by fingers and toes, and is our present way of saying what he would have expressed by "two hands and two feet" or "one man".

I have used this illustration of the historical content of the word "fourscore" because I wish to emphasize that it is by the same methods by which we arrived at its meaning that we arrive at the meaning of mental reactions. We cannot interrogate the mind by the questionnaire method and expect to get very far. The important meanings lie deeply buried in what the psychoanalysts call the unconscious, and they are for the most part incapable of expression in our usual, everyday language. Psychiatry deals with the irrational or non-rational components of the mind—those that are more nearly of pure feeling value. We have been too long fooled by the delusion of man's rational superiority. The significance of the irrational factors is tremendous, and only in this century have they received any adequate recognition.

To illustrate, consider for a moment that ancient part of the cortex known as the archi-pallium, which is, as you know, the olfactory cortex. If I turn to an authoritative work on neuro-anatomy and physiology, I find the statement that in man the sense of smell has practically disappeared and that therefore the olfactory connections are of little importance. As well might one say that counting by fingers and toes has disappeared, but we find its impress in the English "fourscore" and again stamped into the very pattern of the French system of enumeration in *quatre-vingt*. I cannot but recall my teacher of brain anatomy, who was rather inclined to think that the cerebral hemispheres might be considered as outgrowths of the olfactory bulbs. Just as the quadrupedal component of our gait might have had to wait to be picked out and emphasized by some disease before it was recognized, so it may be the same with our olfactory sense. I am thinking of the possible significance of the olfactory aura in epilepsy, and similar phenomena in uncinate fits. In the meantime I am wondering if smell is really so unimportant as our neurological friends seem to think (apart from the fact that a very considerable number of peoples do not shake

hands or kiss when they meet, but smell each other, while as for the organ of smell, the nose, it is sufficient to recall Pascal's remark to the effect that if Cleopatra's nose had been a trifle longer, the whole political geography of our planet might have followed a different course).

Of the importance of odors, the national bill for perfumes would give some vague idea. No doubt, however, vision and hearing have very largely superseded smell, taste, and touch, yet, as before, that does not mean that these senses no longer exist. I am sure they do in many important and intimate aspects of life, and that in the field where they function most, they are less properly the subject of conversation; they have been largely repressed— they will be found in the unconscious.

This unconscious, this repository of our historic past, contains an enormous fund of energy for good and for evil, for from it comes the motive force of our conduct, which, meeting similar or different motives from others and the natural objects of the environment, is molded into those structures, mental and cultural, by which we know man and his civilization. It is this clash of motives between the old and the new, between different individuals, between the individual and the environment other than personal, that gives origin to intrapsychic tensions as the prompt flow of energy from perception or from desire into action is interfered with more or less, and it is the prime function of the psychic apparatus to resolve these tensions. This may, perhaps, be the most general expression of the function of any organ of the body. Nevertheless, the mind is not ordinarily thought of in such terms and thinking of it so is, I am sure, enormously clarifying.

Let us come at another aspect of our subject. It is gradually getting to be a part of medical thought that there is no real distinction between the normal and the abnormal, quite as you may have already inferred that I think that our separation into mind and body is purely artificial and solely for convenience sake. The chemistry of a disordered metabolism is not a different chemistry from that taught in the academic department. The elements will be found to have the same valencies. Just, therefore, as we may properly interrogate a particular organ or function as to its meaning, usefulness,

or purpose in the general scheme, so we may likewise interrogate a disease. We have long known that certain manifestations of disease, such as fever and leucocytosis, were useful, but that is very different from saying that the disease itself, such as typhoid fever, is useful. You will recall that one of the implications of Stockard's experiments with alcohol on the progeny of rats was that constant exposure killed off the weaklings and that the result was a more robust strain. Perhaps exposure to various lethal agents is one of the ways of building up a strong and capable race of men. However that may be, it is not easy to see the value of typhoid fever in the abstract; perhaps we might see its usefulness in a particular case. Whatever the case may be with typhoid fever, I often wonder whether all the knowledge of the hereditarians and the eugenists could sterilize more wisely than the gonococcus.

A more concrete example will bring us to closer grips with the question. I knew at one time a very prominent man who always impressed me as being inherently one of the most timid persons I had ever known. In fact, he impressed me as being actually frightened much of the time or at the slightest reverse. He occupied a powerful position and was known as a most astute manipulator of men and of situations. It seems to me that it is easy to see how fear had made of him a diplomat in his dealings with men. Assuming that his fear was the expression of an anxiety neurosis, then the meaning and purpose of his anxiety can be seen. It was through his powers of diplomacy that he came into prominence. It seems to me, too, that it is not so difficult to understand why this man died of diabetes mellitus. We know enough about the mobilization of sugar to see the connection. Now if we interrogate the diabetes and ask its purpose, the answer is that it was the final stage in an effort at a physiological response to the demands of his anxiety. And finally, when this man died, it was discovered that he had infantile genitalia. Is not this picture of constitution, success by psychological over-compensation, disease resulting from a breakdown of the compensatory mechanisms, and death, a consistent whole? Do not all the parts fit? And do

you not see what I mean by a psychological component of physical disease, and the purpose of disease?

This organ of the mind must be consulted much more frequently than it has been in the past. It will be found to have important contributions to all problems of human origin or interest. Let us consider briefly one or two. I can remember, when I was studying medicine, that if we made a diagnosis of diphtheria, and the patient did not die, we concluded that we had made a mistake. Such was the rigidity of our concepts in those days. We are confronted by a like rigidity of concept in those instances in this country in which an attempt has been made to combat the so-called "crime wave" by increasing the severity of punishment. These attempts are just as ludicrous to the psychiatrist as would be an effort to handle the whole public-health problem of typhoid fever in a community by attempting to reduce the temperature of the individual patients. As the old insane asylum has gradually evolved into the mental hospital, so prisons need to evolve into laboratories for the study of human conduct and the possibilities of its modification along socially useful lines. Hear what Professor Liepmann has to say:

"America might well imitate Germany in its battle against a rising tide of crime, not the Germany of the classical school of penal law, but post-war Germany. The seeds of delinquency and criminality seemed to be powerfully and hopelessly rooted in the period after the last war, the period of the revolution, the inflation, and the economic crisis. But we have not taken up the battle against them by increasing the severity of punishments. We did not follow the advice of those who recommended that we remove a serious natural disease by external radical cures. On the contrary we have, by preventive measures, fought unemployment and juvenile delinquency from the inside.

"During the periods of the greatest criminality, we tried to decrease the importance and power of imprisonment, to free penal treatment from all superfluous and harmful severity and give it an educational value. The result of this work has been a reduction in crime. There is no better example of the utility of the modern school of penal law, no better evidence for the harmfulness of the arguments in favor of

harsh punishments. In America, however, the wrong road has been followed and reliance placed on the electric chair and on pitiless severity. With this, the 'crime wave' and the fear of it have gone hand in hand. It has failed to master the increase in crime." [1]

Then there is another problem of prime importance for the period of civilization we are just entering—the flying age. The psychological component of the problem of flying has been recognized by the assignment of flight surgeons to the various air-service units of the military establishment. As yet, however, outside of certain physiological standards and rather vague notions of temperament, we know very little, and yet we are moving headlong into a period when almost every one will be flying or, as a passenger, will be dependent for his safety upon the ability and skill of a pilot, as we are to-day upon engineers and ships' captains. Two avenues of approach to this problem suggest themselves which, so far as I know, have not as yet received any real recognition. The first is to subject to the most careful psychological examinations possible every pilot who crashes and is not killed, with a view to finding out the psychological factors that preceded and entered into the accident. The second is to examine with the same meticulous care the various superstitions, taboos, hunches, habits, and so forth, of the several members of the air corps, to see upon what they depend and what, if any, part they play in the pilot's performance. There is ample room here for an intensive bit of research work which I am convinced needs to be conducted along psychoanalytic lines.

As regards flyers' superstitions, it seems perfectly obvious that if a given pilot had a peculiarly strong aversion to Friday and to thirteen and had for any reason to fly on Friday the thirteenth, such a necessity might easily condition an emotional imbalance that might account for an error of judgment at a critical time. I remember a boy who had the delusion that a spirit inhabited his thumb. Without entering into the cause for this belief, it is obvious that if he should happen to hit his thumb with a tack hammer, the

[1] *Mental Hygiene Bulletin*, Vol. 6, p. 2, June, 1928.

traumatism would have a much deeper significance than for the average person.

And finally there is the much overworked concept of heredity. Just a word about it and incidentally about another very important matter—namely, culture. The doctor has all too often considered the human individual, his patient, as a unit distinct from every other individual, as a closed system separate from his environment. Of course, such a concept is 100 per cent wrong. The noted biologist, Professor Jennings, goes so far as to say, "Possibly we should be better off with no such concept as heredity; then analysis would be correctly directed toward understanding, in organisms as in other things, in what ways there is dependence on the stuff they are made of: in what ways on the conditions in which that stuff is found." However that may be, we are altogether too glib in attributing all sorts of things to heredity. In regard to psychological characteristics especially we forget that marvelous structure that Herbert Spencer used to call super-organic—namely, culture. Culture is a structure that is built by man little by little, each generation contributing its mite, but that nevertheless has a certain very real independence of any particular man and to a less degree of any group or generation. It is a sort of repository of the successful beliefs and customs that man has come at in his tedious journey and, as an independent structure, it influences all because we are born in it and of it and it is thus a carrier forward of the past quite as truly as the germ plasm. The fact that Mary Smith has the same illness as her mother may no more be dependent upon heredity than that you and I both speak English.

It is necessary that we, the doctors, should treat man not only with a full recognition that he has a mind, but also with an equal recognition of the fact that he is a social animal and that all disease has not only psychological, but social aspects.

You are all fully aware of the enormous social significance of pulmonary tuberculosis, of the venereal diseases, of the cardiopathies, and of cancer, but did you never see a man go down and out while the doctors subjected him to all manner of examinations and found nothing? Such a result comes

from the complete frustration of an individual and was a common occurrence in prisons where the rule of silence and solitary confinement prevailed. The prisoner finally broke under such a régime. Such a frustrating effect can be wrought by a dominating personality, and one occasionally sees such a situation. The emotional stresses become more and more severe until finally something must give way. On the other hand, one also sees miracles wrought by the beneficent influence of a loved person. It is within the field of operations of such forces, which for all I know may have potentialities as great as the unleashed forces of the atoms that the physicists talk about, that the physician works. It is a charmed circle, but the way about it is a complex maze in which we are apt to be lost. But the principles involved are not hard to understand. The patient is the center of all sorts of cross currents of emotional influence from the members of his family, from the doctor, and from the nurses. The practice of medicine must learn how to guide the patient through this maze and how to utilize the forces in this field of operations to his advantage.

All these reactions I have discussed are distinctly human, all too human, reactions of that most distinctive of man's organs, his mind. They span the distance from simple reflex all the way to the complex institutions, financial, judicial, scientific, spiritual, of his civilization. As Dewey says: "We must conceive the world in terms that make it possible for devotion, piety, love, beauty, and mystery to be as real as anything else." Is it possible that we can longer disregard these supremely important and significant qualities of man when we come to treat him as a patient?

PSYCHIATRIC METHODS AND TECHNIQUE FOR MEETING MENTAL-HYGIENE PROBLEMS IN CHILDREN OF PRE-SCHOOL AGE *

LAWSON G. LOWREY, M.D.
Director, Institute for Child Guidance, New York City

IN broad definition, the mental-hygiene problems of the pre-school age are not particularly different from those of any other age group. Two general types of mental-hygiene problems may be recognized: (1) those in which failures in development or in social adaptation are dependent upon distinct types of mental disorders (for example, feebleminded-ness, epilepsy, and organic reductions in reactive or inhibitory capacities such as occur with epidemic encephalitis) and (2) those in which behavior occurs that in one way or another disturbs the people with whom the child lives so that they recognize him as a problem. In general, recognition of the latter group depends upon the fact that some item in behavior disturbs the peace, comfort, or pride of the parents. Some of these situations are unquestionably very serious, but there are other equally serious problems, particularly in the personality field, that are ordinarily passed over by the parent as being of no importance. This is especially true of the very quiet, submissive, extremely "good" child who gives his parents no worry and concern. Nevertheless, this personality mechanism is pernicious because the child comes to live in an inner world from which reality and socializing contact are to a large extent eliminated, and the results of this may, in the end, be very serious.

While any discussion of mental-hygiene problems in children of the pre-school age should logically include problems

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of the first type, they will be disregarded except for this one short paragraph. The psychiatric problem in these cases lies in recognizing the condition, and after the diagnosis has been made, in seeing that proper treatment and proper education are provided and in working with the parents to induce them to accept the limitations imposed by the conditions in question and to prepare them to deal intelligently with the situation over a long period of time. There is no question but that the way in which these children are managed may have a powerful effect in determining their behavior in given situations. Hence the need for work with the parents, the provision of special kinds of education, and the like. Methods of handling these problems, however, are by now pretty well standardized, and varied social machinery is in existence for dealing with them.

We turn, then, to the second group, in which there are four major types of problems to be considered. The first of these is habit formation, particularly those habits that in one way or another are distressing to others. Here would be included thumb sucking, enuresis beyond the usual age, temper tantrums, finicky food habits, sleep disturbances, speech disturbances, nail biting, masturbation (an activity which is, I think, improperly called masturbation is very common in children of the pre-school age), stubbornness or negativism (a common type of faulty habit formation), and oversubmissiveness.

The second major group includes personality reactions, chiefly in the form of emotional reactions manifested in such degree that they may be regarded as excessive. Here we place seclusiveness, timidity, sensitiveness, fears, excessive imagination, fanciful lying, excessive unhappiness and crying, selfishness, restlessness and overactivity, sullenness, revengefulness, excessive irritability (not in the form of temper tantrums), and the like.

The third group comprises difficulties in social relationships, such as fighting, teasing, bullying, impudence, disobedience, show-off behavior, lying, stealing, cruelty, inability to get along with other children, and unpopularity. All these are traits of behavior that the pre-school child, as well as the older child, frequently shows.

The fourth group of problems lies in the field of the develop-

ment of the emotions and their integration in personality, since disturbances in the ordinary development of emotional reactions have a profound influence upon the future success and happiness of the individual.

PREVENTIVE WORK

The ends for which we strive seem to be the success and happiness of the individual now and in the future. Without going into any very great detail, it might be pointed out that the word "success" implies the establishment and maintenance of satisfactory social, economic, and vocational adjustments—that is, satisfying to the individual and not in conflict with the social order. By the word "happiness" is implied a type of life that permits the individual the greatest feeling of security and joy of living and the maintenance of stable conditions of mental and physical health. Since success in relationships with others and the social order at large may enter very definitely into the problem of the securing of personal happiness, the two things seem to be inextricably linked. There is no utopian idea here. The individual can realize success only within the limitations imposed upon him by his innate make-up and the kind of training and life experiences that he encounters. There is no belief that the same kind of success is possible or desirable for different individuals. It is recognized that people find and express happiness in different ways. Perhaps all of this could be expressed by saying that what we are striving for is an individual so well-adjusted personally, socially, and vocationally that he may achieve the greatest success and happiness of which he is capable.

Much has been said and written about the problem of training people for parenthood. Much of it, as emphasized at length elsewhere, proceeds on the basis of making certain sorts of factual studies concerning intellectual and other processes and presenting this material to parents from the standpoint of sheer intelligence as what they ought to do. This seems a most inadequate kind of program. The relationships that exist between child and parent are, after all, primarily emotional, and it is only when we get past these very strong and deep emotional bonds that we come to a point where intelligence partly enters into the situation.

My own idea of parent training can be relatively briefly expressed. We have, first of all, to make people conscious of the emotional bonds that exist between them and their children and of some of the defects in their own emotional reactions toward the children. Once this has been done, intelligence may be turned upon the problem, but until the limitations imposed in one way or another upon the child by the parents are recognized by the latter in terms of their own emotional rejections or fixations, the chance of securing a satisfactory kind of handling is, practically speaking, nil.

The major need, so far as the parent-child relationship is concerned, remains, as always, that the parent shall actually have affection for the child and express it in ways that the child will understand, at the same time viewing the activities of the child with a sense of humor and a certain detached intelligence which helps to make of the child a free agent, although with satisfactory types of emotional bonds.

A second major type of effort in the preventive program is that there be adequate provision for meeting the needs of the child's developing intelligence, emotions, and physique. We deal here with such problems as the proper kind and amount of recreation, and of contacts with adults and children other than those in the family; the wise and unobtrusive surveillance of the child's activities so that they do not become dangerous to himself or too disturbing to others; recognition of the point that play is the child's work and that the doing of things—whether these be abstract or concrete, but particularly the development of the large muscle masses—provides the best kind of training. Through all this there must be a recognition of the child's interests and the satisfactions that the child obtains from various sorts of activities, rather than an imposition by the parent or teacher of things that would satisfy and interest these adults, but that have no necessary relationships with the child's interests and satisfactions.

Even the general statement of such a program is not easy and to lay it out in detail becomes almost impossible because of the variations in children's interests and satisfactions. Nevertheless, approaches can be and have been made, in the nursery school and elsewhere, to the development of various forms of recreation and useful activity. In any program one

should never make the mistake of destroying pleasure in useful activity by thinking of it as "unpleasant work".

In all of life, and particularly during this first period, responses are constantly being conditioned by the association of chance events at the time of the response. Hence always the need for careful study of the meaning of any type of behavior. In fact the fundamental question to be asked about any behavior—whether it be regarded as healthy or unhealthy, normal or abnormal—is: What is the meaning of this behavior? What need or urge does it satisfy in the child? Has it any possible future unpleasant significance? Only by answering these questions can we determine whether a given bit of behavior is to be encouraged or discouraged. The most important element in the preventive program has to do with parents, their attitudes and relationships with their children. I think it is fair to say, so far as behavior in terms of social relationships goes, that the parents are the most important elements in its construction.

TREATMENT OF DEVELOPED PROBLEMS

A reconstructive program hinges around the treatment of the behavior and personality difficulties that may arise in the child. The first element in any such program is the proper diagnosis of the causes of the behavior. The experience of the last few years has taught us a great deal. It is not enough merely to study the child as a physical or mental organism and to make a diagnosis of his difficulties phrased in ordinary psychiatric or physical terms. To be sure, we must know the whole organism as completely as possible from both the physical and the mental standpoints. When we do so know the individual, we become increasingly aware of the fact that there are many parts of the organism that may go astray and that we cannot lump all of these possible changes into some single convenient pigeonhole. Furthermore, we recognize the fact that the individual cannot be separated from his environment. He is constantly receiving stimuli from the environment and is constantly reacting to them. Not only that, but the organism is constantly making its impression upon the environment and so modifying the reactions and stimuli coming therefrom. We have, therefore, to study the entire situa-

tion—the individual and all of the things to which he reacts. The most important elements in the environment are precisely those dynamic elements—the persons—and their reactions and behavior to which the child must react in one or another way.

Aside from the study of the dynamic ways in which the organism reacts, we must recognize that there are limitations in the individual, in his capacities to respond. Not only is this in general a philosophically true statement, but there are many particular ways in which the organism may be limited, as in the case of intellectual inferiority, physical inferiority, some chronic types of disease, and the like. In determining, then, the possibilities of a treatment program, these factors that limit the capacity of the individual to respond must be well known and completely evaluated in terms of their present and future significance.

Diagnosis, then, becomes a matter of study of the people with whom the child lives, of his relationships to them, of his relationships to other people and to all types of tasks he may have to face, and of himself as a physical, intellectual, and emotional organism. Only on such a well-rounded study is there a possibility of erecting an adequate program for treatment.

When we come to treatment, we have to recognize that there are two major points to which our treatment program will be directed. There is, first of all, the child himself. Here a great many different methods have been worked out. A brief resumé of some of these follows.

What may well be called the Adlerian method depends upon the recognition of various mechanisms that produce feelings of inferiority and compensatory behavior in the attempt to dominate a given situation. The chief element in this method of treatment appears to be giving to the child a sense of his own importance and worth-whileness and at the same time bringing him into contact with an individual who is sympathetic and who expects from him the best in the way of behavior. In certain of Adler's work—as, for example, work carried on in the public schools in Vienna—not only the influence of the teacher, but the influence of the group of pupils who are in the class is brought to bear on these problems of behavior. One of the most dramatic experiences I have ever

had was sitting through a session in which thirteen-year-old boys were discussing the behavior of themselves and other people, explaining it in psychological terms and setting up ways in which it could be modified so that it would be socially acceptable and at the same time personally satisfying.[1]

Psychoanalytic methods have been used. To some extent, in the interpretation and treatment of every behavior problem, the knowledge of mental mechanisms gained from psychoanalysis is of importance in understanding what is going on. On the other hand, as a therapeutic technique, psychoanalysis is applicable to only a limited group of cases, primarily in older children than the age we are discussing and then on the basis of a definite symptomatology for which psychoanalysis is the indicated method of attack, whether the symptoms occur in children or in adults. Thus hysteria, or hysterical symptoms, would lead to the use of such therapy.[2]

Another method very commonly used, though considerably less in this country than abroad, is what might be called the "staged show". Here the child is brought to the doctor in front of a small or large audience, usually including one or both parents and other members of the family if they are available, visiting physicians, medical students, and other people who are interested in the clinic. The child's behavior is gone over in detail in front of him, and often some sort of explanation is given of what the behavior means. The type of explanation and its adequacy will be determined by the type of psychiatry that the examining physician is capable of using. Thus, in France, problems in behavior are explained by the psychiatrists in terms of constitutional limiting factors, which indicate that the child could react in no other way. More or less of a lecture may be given to the child. Or, on the other hand, a very sympathetic approach may be made to his problem. At times, group of cases that present similar problems are brought together and set to working out their problems in competition. In any case, the method seems not to allow for certain factors of shame, feelings of disgrace, feelings of

1 Cf. *The Practice and Theory of Individual Psychology*, by Alfred Adler. New York: Harcourt, Brace, and Company, 1924. pp. 59–77, 339–50.

2 Cf. *The Technique of Child Analysis*, by Anna Freud. New York: Nervous and Mental Disease Publishing Company, 1928.

being lectured, and the like, which, to judge from our own experience, must be avoided if we are to secure the best results.

Many cases present some type of problem in physical therapy, and wherever this is true, the therapy should certainly be given. There are times, however, when it is assumed that the physical therapeutic problem alone accounts for the behavior difficulties. We have never yet seen a case in which there was not also some psychological mechanism connected with the physical difficulties. In fact, physical difficulties operate chiefly, so far as behavior is concerned, by determining (1) certain limitations in capacity to react which (2) lead to oversolicitude on the part of the parents and the development of a pernicious situation in which the child is the center of attention, and (3) certain conflicts over differences between the activities permitted the child and those in which other children may engage. In our experience the latter two mechanisms are by all odds the most important and they must be met as well as the physical problem.

Some methods are described as methods of persuasion and direct contact. I would point out that in general whatever effects are achieved in direct contact with the child are in direct proportion to the emotional rapport between the psychiatrist and the individual. This emotional rapport has been called by the psychoanalyst the "transfer". What it seems to amount to in the case of children is something like this: The therapist becomes a kind of ideal or the repository of ideals which the child hopes to reach. From the emotional standpoint the child's satisfaction is achieved by inducing emotional responses in this individual (father or mother substitute). This is true no matter which of the methods previously described may be under discussion. The Adlerian method depends definitely upon the development of the transfer and the setting up in the child's emotional life of a satisfactory emotional relationship with the therapist. In fact, Aichhorn, one of the leading Austrians, describes his method of dealing with behavior problems in children as one of attempting to understand intuitively what is going on and then making a conscious use of the transfer in treatment.

To this developed emotional transfer situation must be

added an intellectual approach to the problem as well. This intellectual approach involves analyzing the meaning of the child's behavior, what satisfaction it is striving for, and evolving, either with the child or otherwise, other more acceptable means of reacting which will still permit the attainment of emotional satisfaction. With older children, this analysis is often made directly with the child, throwing the responsibility back upon him once he has clearly understood the real meaning of his behavior (I do not need to emphasize that I use "analysis" here in the ordinary sense and not in the sense of psychoanalysis).

In all the cases of behavior disturbances with which we have dealt, we have found that the problem could not be solved and treatment be finally satisfactory without taking into consideration the problems in the environment which in one or another way, usually as stimuli, are related to the behavior shown. This "indirect" approach to the problems of the child should never be neglected in the treatment of any situation, no matter how much direct work may be done.

SOME HOME PROBLEMS

In the pre-school age we are dealing primarily with the problems of the home. Many points arise. The attitude of the parents toward their children and expectations for them; the parents' ideas of discipline; their knowledge of what to expect of a child at given ages; the ambitions they have which lead them to push the child in one or another direction; their attitudes toward their own childhood experiences and their attempts to eliminate or correct the unpleasant ones in the lives of their children; the emotional bond between the parents; their emotional reactions toward the children in terms of their love, pride, and so forth; the fixation of one of the parents upon the child as a love object in substitution for some other love object which has been unsatisfactory; their attempts to revenge themselves upon the child for frustrations in their own lives which they cannot otherwise manage; and so on through a long list of emotionally determined attitudes which may be extremely upsetting in the evolution of the child's patterns of behavior.

There is also the question of the routine of the household;

its system or lack of it; the kind of training to which the child is exposed; the sort of things that he is permitted or encouraged to do and the possible future difficulties that these activities may produce. Many parents, for example, will permit certain sorts of activity while the child is small and then be tremendously upset by the same kinds of activity when the child is older.

It is certain that those in the front-line trenches can rarely have a clear idea of the whole battle. So it is with parents in their relationships with each other and with their children. Being deeply engaged emotionally in one or another way, it is very difficult for them to make a clean-cut, objective analysis of the situation, and it is often extraordinarily difficult for them to change their ways or methods, unless guided from the outside. Hence the development of a series of extra-home facilities for dealing with behavior problems.

For this there are certain other reasons also. The smaller size of the modern home; the grouping together in smaller areas of larger and larger masses of people; the assumption by agencies outside the home of the major tasks of producing and distributing the things that are needed to maintain the individual physically; the going out of mothers to work; the increasing emphasis on money as a medium of exchange; the isolation of the family from its own larger family group—all these have contributed to an increasing need for extra-home facilities. So we have the nursery school; the development of small groups of children who live and play together during certain sections of the day; the development of systematized recreation; and various kinds of clinics for studying the physical and mental problems of children. The latter clinics, whether called habit clinics, child-guidance clinics, psychiatric clinics, or whatever, are all concerned with the study of the whole individual and his situation, and it is only through this, and then through well-defined efforts to utilize the social machinery available and to change the existing patterns and attitudes in homes, that we may hope to deal with the problems of childhood in such a way that the behavior difficulties and mental difficulties of later ages may be prevented.

PERSONAL FACTORS IN RELATION TO THE HEALTH OF THE INDIVIDUAL WORKER

C. MACFIE CAMPBELL, M.D.
Director, Boston Psychopathic Hospital

IN medicine, of recent years, emphasis has been laid on the personality of the patient and on the situation in life that he has to meet; attention is no longer almost exclusively concentrated upon the impersonal processes of disease, upon questions of infection, and upon the disordered chemical activity of the system. Too exclusive reference to the impersonal processes of disease had led to the temporary neglect of other important factors. Renewed attention is being paid to the fact that even simple physical symptoms may turn out to be the expression of emotional tension in the patient's life, and that we can neither understand nor treat the symptoms adequately unless we understand and treat the patient himself and perhaps modify the situation to which he has to react. The same tendency which has led to the broader conception of health, and which has shown that one cannot, with impunity, fail to take into consideration the complexity of human nature even when dealing with physical symptoms, has received a much wider application than merely in the medical field. In education it is more and more realized that retardation in school, lack of concentration or of docility, waywardness of behavior, and the like, are not merely pedagogic or school symptoms, to be treated according to the traditional methods; they are symptoms which perhaps can be understood only when we study the whole child and scrutinize the atmosphere of the schoolroom, of the playground, and of the home.

In another field of human adaptation the same principle is being slowly established; in dealing with delinquents or criminals the tendency is not to be content with treating the delinquent act merely by the application of traditional methods, but rather to study the individual delinquent and the

situation to which he has responded and to consider the best procedure in the individual case.

A review of man's activities in modern biography and history shows that the tendency is not to deal with merely external happenings and to describe and classify them under familiar and somewhat threadbare terms, but rather to trace events to the basal forces of human nature and to show how actual occurrences are related to the fundamental human needs and urges of individuals and of groups.

A great deal of the stimulus to this work has come from the therapeutic study of individual patients with nervous disorders, and the light thrown upon the mechanisms of human nature by such study has raised important questions as to the possible prevention of much maladaptation. Hygiene is being more adequately conceived and is beginning to include preventive work in relation to a great variety of later maladaptations. The hygiene of the school child is no longer adequately represented by attention to his nutrition, to his teeth and tonsils, but includes cognizance of his habits, his emotions, his personal relationships. The teaching profession is on the alert for all new information related to this field.

In industry, too, the emphasis on the personal note, on the emotional and instinctive factors at the basis of behavior, on components of the human machine which are not related merely to special technical skill, is becoming more obvious. Industry, enterprising, aggressive, and always on the alert, wishes to know what information is available that can be utilized to meet its special needs. The more definite and precisely formulated the information, the more acceptable will it be. Where the information points clearly to any special change in procedure or to well-organized activity, the more likely is it to be received with gratitude. It is here, perhaps, that the optimistic and the over-eager and the impatient will be sadly disappointed, for the available information is, after all, somewhat fragmentary. It covers a wide field which touches large issues; it is not easy to reduce it to a simple and easily grasped summary of facts. The direction in which these facts point, the suggestions that they give as to modification of existing organizations, may

also be rather uncertain and may not always be interpreted in the same way by different individuals. In view of the comparative novelty of this body of knowledge with regard to human nature, its underlying mechanisms, its special adaptations, in view of the limited information and the uncertain application of it, many who are interested in industrial affairs may stand aloof, indifferent, somewhat distrustful, and even those who are receptive may feel rather defrauded when, instead of a prescription, they are offered only a point of view.

At the present time those who are working in the medical field feel that the point of view and the methods there utilized have a much wider application than merely in the treatment and prevention of what is usually referred to as sickness. They feel that the same methods and results can be applied to wider fields of human endeavor, and while continuing their researches in the medical field, they respectfully put at the disposal of other groups the data that they have accumulated. It is for those in the other fields, of course, to determine what facts thus obtained are of value to them in their special field, whether it be the field of education, of jurisprudence, or of industry. The present paper attempts to present this point of view to those who are interested in the industrial field and to show by a few examples that the factors which the physician comes upon in meeting the demand of a patient for the alleviation of symptoms are factors that may be of interest to the industrial expert who is studying the behavior of workers — their efficiency, their contentment, their mutual adaptability, their acceptance of discipline, their self-confidence, their initiative.

A senior executive in an industrial company consulted a physician because he was sleepless and was worried over some disturbing sensations in his tongue. The physician found no local condition in the tongue to justify the slightest uneasiness on this score. The unnecessary worry over the trifling symptoms and the sleeplessness were found to be related to emotional tension in the patient's life, to rather special preoccupations, and to a rather eager straining after high attainments. From the point of view of the alleviation of symptoms, the treatment indicated was to give the patient

an opportunity for relief of the emotional tension by a systematic review of his personality with its underlying needs and tensions. In social life this man had an urge to be an active leader in church work. In the industrial sphere the same urge led him to be active in giving advice both on technical and ethical questions. His inability to get other workers to handle their problems in the way in which he thought right was a source of worry and annoyance to him.

In this example we have a man with certain symptoms, who is, therefore, a health problem in the current sense of the term health, but the limited health problem is only one small outcropping of the problems involved in the personality of this man. The same problems also crop out in his attitude toward the workers in his own organization. The undue seriousness and intensity of his life—the patient, an earnest and high-minded man, had never learned to play—were in part determined by the home situation. He had a very conventional wife and their relations were largely determined by a puritanical outlook which was common to both and which interfered with a completely satisfactory personal hygiene. The wife found her outlet in social activities; the patient's surplus energy and nervous tension overflowed into the business field.

While these data were revealed in the course of an examination that had been made because of physical symptoms, one can easily conceive that in the industrial setting there might have arisen difficulties based on exactly the same factors. If such business difficulties are to be dealt with adequately, perhaps one may have to realize that they are the expression of underlying factors, and that the most satisfactory solution of the situation can be found only when these personal factors have been dealt with. The special characteristics of the patient which seem to be a reaction to underlying difficulties may, within limits, be an asset, and beyond these limits a liability. His eager initiative, his high standards, his missionary enthusiasm might be a source of inspiration to his organization. On the other hand, his insistence on extremely high standards, his discontent with actual accomplishments, his worry over inability to get the results that he

himself desired might be a source of irritation and friction and restlessness within the organization.

A contrast to this first case is that of a gang foreman of approximately the same age, who complained of lack of ambition and a tired feeling, and who was uneasy on account of certain numb feelings in his hand. There was nothing in the man's condition to give any real basis for this uneasiness. His physical condition was very satisfactory. In the case of this foreman, in contrast to that of the executive, the factors that seemed to have brought on the symptoms were external situations and circumstances and not repressed factors within his own nature. He had worked for two years without a vacation; he had lost a son the year before; his uneasiness over his own condition was partly determined by the fact that his brother had had a mental breakdown, so that he himself was apt to interpret any symptoms in a very serious way.

While in the previous case the symptoms might be looked upon as symptoms of tension, in this case one is dealing rather with symptoms of deprivation. For normal health and efficiency, there must be a reasonable balance of work and play. Life must be of some interest and must offer opportunities for some satisfaction. Where the work is dreary and in itself uninteresting, there must be some source of satisfaction outside of one's work and there must be some reasonable time for this satisfaction. There must be reasonable recreational opportunities in the community, opportunities for social relaxation, and in some cases individuals may need to be encouraged and even trained to use the opportunities for relaxation that are available. The undue emphasis by the patient on his minor physical symptoms was partly determined by the history of his brother's condition. In such cases much can be done to give the individual simple information with regard to the facts of heredity and to remove unnecessary apprehension. As to his bereavement, the extent to which he and his wife had been overwhelmed by this bereavement was, no doubt, partly determined by the very limitation of their lives, the lack of recreation and adequate social relaxation and external interests. In this case again we have, to a certain extent, an obvious health

problem, with disturbing bodily feelings and an attitude of discouragement, but the health problem is only one element in a total situation, that of a worker whose life is unhealthily narrow and one-sided.

From the industrial standpoint it may be a question how far a foreman in a situation like this is a somewhat vulnerable link in the organization. With natural interests and faculties undeveloped, there may, on the one hand, be a feeling of depression and lack of ambition; on the other hand, there may be a vague and slumbering discontent or an underlying resentment of which the individual himself may not be clearly conscious, but which determines his attitude toward the management and toward his fellow workers.

A narrow and restricted life, with lack of recreational and cultural activities, is not limited to the manual worker. Thus a man engrossed in his financial and professional activities had little stability of mood. His spirits rose and fell with the varying fluctuations of business. "I do not know how to play", he said. "I have given up everything to family and business." He was studied as a medical problem, as he had a vague uneasiness and morbid fear, was always anticipating bad news. The analysis of such an apprehensive attitude takes one deep down into the basal forces of human nature. While these forces had manifested themselves in an uneasiness that happened to be brought to the attention of the physician, one can see that this uneasiness and anticipation of calamity and variability of mood might express themselves in a rather disconcerting way in his attitude toward industrial decisions.

At the other end of the industrial scale is the case of a young girl of eighteen who had suffered from fainting attacks and who had told her fellow workers various fantastic stories. On the surface it might seem that we were dealing here with two quite different problems — on the one hand, fainting attacks due to some bodily ailment, and on the other hand, untruthfulness, a problem rather for the moralist than for the doctor. A review of the whole situation, however, showed that the fainting attacks and the fantastic stories were of the same cloth; they represented the romantic and dramatic enrichment of a life which had been seriously thwarted

through rather sordid family surroundings. In such a case the problem is no simple one, to be solved by a tonic or a sedative, but that of gauging the satisfaction which the real situation offers to a girl of a somewhat romantic and imaginative nature. It is not a problem for the physician alone; it involves a study of the patient's industrial environment, the home environment, and the recreational and cultural opportunities available.

The importance of recognizing the personal or emotional origin of physical symptoms in cases of this type, in order that the correct medical treatment may be instituted, is obvious. Failure to trace the underlying factors and exclusive attention to the superficial symptoms may mean an extremely protracted period of incapacity. This is well illustrated by the case of a young girl of twenty-one who was seen on account of vomiting, loss of appetite, weakness, and abdominal pains. The illness had been of considerable duration and was attributed to a slight head injury received in the course of her occupation. Attention had been concentrated on her physical symptoms. The usual technical medical procedures had been applied. X-ray pictures had been taken, chemical examinations made, special appliances worn; a rather drastic operation had even been suggested as a possibility. During all this period the girl had been treated very generously by her employers, so that she had been a source of considerable expense to her company. When a thorough review was made, not only of the physical condition, but of the personality of the patient, of her experiences in life, of her personal difficulties, the diagnosis was that the symptoms were, at least to a very large extent, based upon emotional conflicts. The degree of her incapacity had been determined much less by actual bodily weakness than by the way in which she had reacted to incidental and somewhat trifling symptoms, on the basis of which she had come to play the rôle of a serious invalid both to herself and to others. The explanation of the underlying mechanisms of her trouble was at first received by the patient with some antagonism and protest, but a frank discussion of the whole situation and of her personal problems proved to be of the greatest benefit to her.

From the medical standpoint, such a patient presents many

fascinating problems with regard to the original constitution of the individual, the molding factors of her life, the special situations that offer most emotional difficulty and are most likely to lead to such a type of invalidism. Why does this patient break down in relation to a situation that others can meet without special difficulty? Why do the physical symptoms take this form rather than that form? Could better training in childhood, the formation of better habits, a more open and intelligent and tonic atmosphere, have prevented the later symptoms? What is the precipitating factor that causes the symptoms to develop just at this time? Why do the symptoms persist for such a long time? Each one of these topics would furnish a subject for a prolonged and intricate discussion of a very technical nature. The broad, outstanding factors, however, are simple.

The case is that of a young woman who, after a trifling accident of little importance, becomes incapacitated for months while her organization treats her in a considerate, even generous way. The duration of the symptoms and their intractability were perhaps in part fostered by this generous and tolerant attitude of the organization. On the basis of her symptoms, she received compensation, was an object of sympathy and concern to friends and family, and, at the same time, found a safety valve for the inner tension connected with instinctive and emotional factors. It must not be assumed that in such a case there is conscious deception or that a patient deliberately tries to deceive others. On the other hand, the duration of the incapacity is to a large extent determined by the gain derived by the patient from the incapacity, a gain that may be partly financial and partly psychological. In this case there had been a minor injury and this was used as a peg upon which the clinical symptoms were hung.

The way in which a worker responds to an injury, the degree and duration of the incapacity, are, to a large extent, dependent upon the personality of the worker and the way in which the situation is handled by the management. In some organizations this is recognized, and the situation is treated with great wisdom, so that there is the minimum opportunity for the worker to develop an unhealthy attitude

toward his injury, to concentrate too much attention upon the incapacity and upon the responsibility of others for compensation, while the maximum attention is paid to encouraging him to look forward to a full resumption of work, and stimulating him to carry on with what capacity he still has. The management thus keeps the worker from being influenced by undue solicitude and by the suggestions of others who overemphasize the disability, and so deals with the problem of compensation that the worker is not preoccupied with the thought that the compensation will be in proportion to his emphasis on his symptoms and to the degree to which he feels incapacitated.

It is in the best interest of the worker himself that the treatment of any injury or sickness should lead to the quickest possible return to health and general efficiency. In the interest of the worker himself many elements that foster a feeling of incapacity, a disinclination to resume work, a tendency towards dependence upon others, should be guarded against. It is well, therefore, to keep in mind—what seems to be quite clear from the study of cases outside of the industrial sphere—that symptoms of the most varied type may be perpetuated by the attitude of those around and by the advantages that accrue to the individual from the existence of symptoms. Those who have been in close contact with the problems of the disabled soldier realize how detrimental to the individual soldier has been the tendency to keep his mind focused on the problem of compensation rather than on that of the resumption of life's activities. The same factors that tend to foster emphasis on the results, real or fancied, of some injury are also at work in connection with the other ailments that assail the industrial worker, and here, too, the degree and duration of the incapacity may be related to personal factors, which must be kept in mind by the medical personnel and by the management.

The extent to which such personal factors interfere with the continuity of the industrial career of the worker is illustrated by the case of a young woman who was working in the same organization as the patient just mentioned. In the present case the symptoms were those of some respiratory distress and a certain general nervousness. Here, too, there

had been a detailed review of the bodily functions, and the patient had received medical care for a considerable period and for many months had been at home, apparently unable to go on with her occupation. Her preoccupation with her symptoms was in great contrast to her actual physical condition, which was quite satisfactory. Her restoration to a healthy attitude toward the resumption of work, with disappearance of the symptoms, was dependent upon her facing honestly various personal difficulties which had been a source of great concern to her, but had never been discussed.

In many cases the incapacity of the worker, whether it take the form of physical symptoms or of some peculiarity of attitude toward those around or toward self, is based upon personal factors closely related to the instinctive life which are seldom discussed except in the frank atmosphere of a medical consultation. The benefit to the worker of a frank discussion of some of the fundamental issues of life may be very striking. The following case illustrates this relationship of work inefficiency, nervous symptoms, and underlying human difficulties.

The patient, a middle-aged man, was suffering from headache, somnolence, and odd head feelings. He had lost his usual ambitious and progressive attitude toward his work. Examination showed no physical disorder except undernutrition. There was a lack of harmony at home, and his wife had rather rigid and puritanical standards. The situation was not unlike that of the first patient whom I referred to in this paper—the executive who tried to find an outlet in a missionary attitude toward his environment. In the present case, a thorough discussion of the fundamental issues that were at the basis of the domestic discord, and the placing in the hands of the wife of a book which gave her much information and a completely new attitude toward the basal factors of human nature, brought about a complete transformation of the domestic situation and the disappearance of the symptoms that had brought the patient to the attention of the physician.

These few cases, presented in a very sketchy way, illustrate the problems that come to the attention of the physician. In dealing with the symptoms of his patients, he sees the im-

portant rôle played by personal factors, the importance of the fundamental instincts of human nature, the influence of the domestic, the social, the industrial situation upon the development and the persistence of symptoms. He sees that the underlying forces uncovered in his study manifest themselves, not only in medical symptoms, but also in reactions in the schoolroom, the store, the factory, and the office. He wishes to make his data available to those who are working in the school and in the factory, so that they will have a still fuller grasp of the personal problems and needs of those with whom they are in contact, not to mention a fuller grasp of the problems that determine their own personalities, their attitudes toward life, their standards of values.

Where underlying difficulties express themselves on the surface through physical symptoms, the individual is liable to come fairly early to the attention of the physician. But where the same type of underlying difficulties express themselves in a somewhat changed attitude toward fellow workers and toward the job itself, the physician may not see the individual at all while the individual is one of the problems of industrial management. The management has to take account of workers who feel rather sore at other workers or groups of workers, who feel that they are discriminated against, who see hostility and injustice in the attitude of others toward them. It is perhaps generally realized that if a foreman is having difficulty with too many of his men, the fault may be in himself. It is not easy, however, to check up on one's self without the aid of some detached observer. The same repression of underlying factors that has led to the friction is apt to lead to a certain blindness when we try to scrutinize our own conduct. An example of the way in which the individual sees in the behavior of others a disturbing attitude toward himself, which has its root really within his own personality, is furnished by the following case.

The worker, a man in the thirties, had been promoted to be a foreman and now felt that his fellow workers did not like him. They did not seem to respect his authority. "I felt that the men were trying to put the skids under me at work." As a matter of fact, the patient felt a great deal of diffidence about his ability to play the rôle of foreman. He

had lost confidence in himself. This loss of confidence, however, seemed to have its origin, not in any real inefficiency, for he was an excellent workman, but in his self-reproach over his domestic life in which he felt that he had been disloyal and criticized himself rather severely. There seemed reason to see this personal discontent with his own private life as the real basis for what, on the surface, was a statement that those who were working with him disliked him and were essentially hostile and critical.

In a similar way the persistence of an old repressed attitude of resentment against parent or teacher may show itself in the industrial environment as a somewhat exaggerated and inappropriate resentment of all authority and discipline.

The practicing physician has his own special occupation of looking after the ailments of those under his care. In addition he has an interest in promoting research into the causes of the troubles that he is studying; he has an interest in the health of the community at large and in the wider problems of social welfare.

Those who work in industry have their specific tasks, but besides their interest in their own technical task, they may have some interest in promoting research into the various factors that influence the welfare of an industrial organization; they may have an interest in the social welfare of the community. Even in doing the special task, it may be of some advantage to them to have a more specific knowledge of the way in which underlying personal factors influence the total behavior of the individual, whether the individual be a worker at a repetitive task, a skilled craftsman at his special job, an office employee dealing with mental operations, a foreman supervising and managing human material, a manager organizing, planning, coördinating, a salesman with his special problems of appeal and influence, a president inspiring, dominating, delegating authority, making decisions, employing strategy.

What can the physician say in general about the individuals who compose the highly organized industrial community? What is the common denominator? The common denominator is the basal endowment of human nature. The underlying

driving forces of human nature are the same, from the worker at the machine to the president in his office. There are variations in the quality and degree of these component forces, but each individual is aiming at some sort of harmonious satisfaction of these component tendencies. The urge to live, the urge to love are common to all; fear in the face of danger and uncertainty, anger in the face of thwarting, are the heritage of each one. Satisfaction from the approval of one's fellows plays some rôle in determining the behavior of each one, and each one has some standard of values, some code, some scheme of life, whatever may be the origin of this scheme and however vaguely formulated it may be.

It is with these common factors that the physician has to deal. In the face of pain, of weakness, of unhappiness, of incapacity, he has to examine the common factors in human nature; he has to put aside all conventional reticence and to deal with life in its bare reality. Where it is a question of life and death, whether of the body or of the mind, reticence and reserve are out of place, and the physician has to study human nature and human situations with a directness and frankness that no other situation makes quite so imperative. In the study of the physical and mental health of his patient, the whole patient has to be explored—his physical organs, his emotions, his instincts, his early home influences, his intimate past experiences, his present life situation. The physician cannot fail to be impressed with the subtle ways in which the deep, underlying forces of human nature express themselves above the surface in symptoms and behavior, the significance of which is so apt to be misunderstood. He feels that the knowledge of human nature thus derived is of sufficient importance for him to take the initiative in bringing it to the attention of the teacher, the religious adviser, the sociologist, and the industrialist, so that there may be greater coöperation in the interest of the common welfare.

THE MENTAL-HYGIENE ASPECT OF THE BOY-SCOUT MOVEMENT *

WILLIAM C. MENNINGER, M.D.
Topeka, Kansas

MANY attempts have been made to place boys of the adolescent age in groups under adult leadership with the chief purpose of affording guidance in the boy's physical and mental development. In 1910, the Boy Scouts of America were chartered by Congress and since that time have been one of the greatest socializing forces for the adolescent boy. The great bulk of the Boy-Scout organization is composed of units of thirty-two boys, or less, known as the "troop", under the direction and leadership of a volunteer adult "Scoutmaster" and his adult assistants. Where there are sufficient troops in a locality, they are centralized under the direction of a paid "executive" into a "council". Various councils are grouped together under a "regional executive", all of whom are responsible to a "national council", headed by the "chief Scout executive".

The purpose of the Boy-Scout organization, as stated in its constitution, is "to promote, through organization and coöperation with other agencies, the ability of boys to do things for themselves and others, to train them in scoutcraft, and to teach them patriotism, courage, self-reliance, and kindred virtues". The organization recognizes the religious element in the training of the boy, but it is absolutely non-sectarian in its attitude toward that religious training. It definitely avoids all questions of a political character and specifically states that military training and drill shall not be included in the program.

The program of the Boy Scouts of America is carried out through the organization of the troop, which consists of at least one, and not more than four, patrols of eight boys each,

* The author of this article has had seventeen years of experience in the Boy-Scout movement and at the present time is Scoutmaster of a troop that has twenty-four Eagle Scouts, the highest rank in the organization.

each patrol being under the leadership of a boy—the "patrol leader". Only boys who have passed their twelfth birthday are eligible for membership, and the upper age limit is eighteen years. The program is one that recognizes the achievements of boys by the award of degrees and badges which designate them progressively as Tenderfoot, Second-class, and First-class Scouts, and by the award of special-merit badges for proficiency in the subjects of woodcraft, art, crafts, agriculture, science, nature study, physical development, and so forth.

All Scouts must know and subscribe to the Scout oath and law. The oath is as follows: "On my honor I will do my best to do my duty to God and my country and to obey the Scout law; to help other people at all times; to keep myself physically strong, mentally awake, and morally straight." In subscribing to the law, a Scout promises to be trustworthy, loyal, helpful, friendly, courteous, kind, obedient, cheerful, thrifty, brave, clean, reverent.

Upon demonstrating his ability to repeat the Scout oath and law in full and his thorough knowledge of their meaning, and in addition learning certain knots, the history of the American flag, and a few other things, a boy is entitled to wear the Tenderfoot badge. After a month's service as a Tenderfoot, he may qualify as a Second-class Scout by learning some of the simpler forms of first aid, tracking, fire building, and elementary signaling and cooking; starting a bank account; and fulfilling some other simple requirements. After sixty days' service, he may qualify for the rank of First-class Scout by passing certain more difficult tests, including swimming; advanced signaling, first aid, and cooking; map making; hiking; and nature study. He may then advance by demonstrating his knowledge and skill in one or more of some eighty-five fields of endeavor — such as archery, architecture, athletics, camping, bird study, dairying, life-saving, photography, surveying, and so forth.

By acquiring any five merit badges, a Scout may qualify as a Star Scout; ten merit badges make him a Life Scout; twenty-one — eleven of which are specified — give him the highest rank award in Scouting—that of Eagle Scout.

The basis for the success of the program of Scouting from

a psychological point of view lies in its ingenious methods of applying and uniting various psychological factors, all of which are particularly beneficial from the standpoint of mental hygiene.

The first of these psychological factors is the appeal made to the ego and the gratification of ego desires. The program brings a boy to a new awareness of himself. He voluntarily begins to educate himself to qualify as a Boy Scout—a step he may have looked forward to for years. He crosses a threshold of new opportunities that open up visions of much romance and interesting experience. He acquires the privilege of wearing a uniform. He is introduced to ceremony and government. He is given the opportunity to advance in rank and he may decorate himself with his awards to display his accomplishments. He becomes aware of positions of responsibility that are open to him as soon as he qualifies himself for them. He is invited to test himself, and the whole plan of advancement in the Scout program is an individual affair which is rarely, if ever, colored by group competition. Every test is a personal problem, and the Scout competes against nothing but his own impediments of lack of skill or knowledge or ability. Thus, as stated in the report of the Committee on Habits of Conduct as Fostered by Scouting,[1] if the Scout wins in the test, he is a more skillful, useful, serviceable, dependable individual to himself and society. If he loses in the test, he is still a winner because he has made progress in the pursuit of good habits and has attained a certain measure of initiative and self-mastery.

The second psychological factor that works for the success of Scouting is the development of a group consciousness. Much has been written about the natural growth of a boy out of his family bondage into the "gang". The troop becomes the "gang" and supplies the common interests, the mutual objectives, and the opportunity of group association, but it differs from the usual "gang" in its continuity and adult leadership. In the writer's experience, the majority of boys who join the Scout troop are attracted to it primarily because their friends are members. They join to become a

[1] Submitted at the Fourth Biennial Conference of Scout Executives, Hot Springs, Arkansas, September 22, 1926.

member of the gang. The Scout's uniform identifies him as belonging to a great group, and his colored neckerchief, which is a part of that uniform, identifies him with a particular local group, around which more or less group morale, tradition, and distinctiveness always crystallize. The troop usually gets together each week, and this group consciousness is purposely strengthened. There the younger boy is brought into direct contact with older boys and adult leaders. This gives the boy of twelve or thirteen years an unusual opportunity to become intimately acquainted with boys of seventeen and eighteen years, and the younger boy's desire to emulate the older boy is accentuated much more than in the ordinary "gang" because of the plan of Scouting, the exhibition of insignia and badges that show accomplishment. The older boy, on the other hand, is stimulated to further personal development by the responsibility of leadership vested in him.

The third wholesome psychological factor in the Scouting program is the direction of the boy's energy into purposeful lines of activity, into the acquisition of useful facts and practical accomplishments. The boy is introduced to a great variety of new interests, covering every field and presented in such a way as to appeal to boys from the age of twelve even past the upper limit of eighteen years. The tests are literally a man's job cut down to a boy's size, and there is sufficient variety to appeal to the versatility of the average American boy.

The technique of this introduction to knowledge is regarded as unique in our present educational development by certain of our leading educators, who praise the educational value of Scouting in glowing terms. For example, James E. Russell, while Dean of Teachers College, Columbia University, has expressed himself as follows: "The Scout program is essentially moral training for the sake of efficient leadership. It gives definite embodiment to the ideals of the school, and supplements the efforts of the home and church. It works adroitly, by a thousand specific habits, to anchor a boy to modes of right living as securely as if held by chains of steel; but best of all, it exhibits positive genius

in devising situations that test a boy's self-reliance and give full leadership. These two aspects of the Scout program are so evenly balanced and so nicely adjusted as to make them well-nigh pedagogically perfect. The entire organization is a machine capable of working wonders, not only in the moral regeneration of the American boy, but also in fitting him to assume the duties of an American citizen." And Lotus D. Coffman, President of the University of Minnesota, has stated:[1] "Scouting gives no long lectures on vocational guidance, and yet it teaches the meaning, the importance, and the dignity of work; it operates no bank and yet it teaches the meaning of thrift; it maintains no jail and yet it teaches the meaning of self-control; it does no preaching, and yet it teaches devotion to a cause and loyalty to a purpose; it is founded upon no religious creed or sectarian doctrine and yet it emphasizes above all things the importance of religion. It is universal in its appeal, natural in its methods, progressive in its outlines, strengthened and cemented by the bonds of fellowship, and the idealism of the movement. Majestic in its conception, it is nevertheless simple and direct in its appeal. I believe in it so fully that I can truly say that I would rather have been its author than to have been the author of any other thing I can think of in the whole field of social theory and practice of my day and generation."

Dean Henry W. Holmes, of the Graduate School of Education of Harvard, and Professor William H. Kilpatrick of Teachers College, Columbia University, have also made public statements of their opinion as to the unusual educational advantages of Scouting.

The fourth and perhaps the most powerful psychological factor in the application of the Scouting program is the transference developed by the Scout to his Scoutmaster. By transference, the writer refers to the unusual interest, akin to affection, which the Scout develops toward his leader. The Scoutmaster figuratively becomes the idol, the hero, the originator, and the father, and the boy, the idolator,

[1] Quoted from *Scouting in Relation to the Schools*, by Ray C. Wyland. New York: Boy Scouts of America, Department of Education, 1927.

the worshiper, the follower, and the son. He responds to his leader with an unstinting devotion of time and energy to assigned tasks and loyalty to ideas, and follows out the leader's suggestions to the limit. Just in so far as a man can obtain this transference from boys will he be a successful Scoutmaster, regardless of his technical knowledge of the organization and program of Scouting.

Failure on the part of the Scoutmaster to appreciate this point is probably one of the weakest features in the whole organization of Scouting. The Scoutmaster is a volunteer contributor of his time and energy, and far too often he takes his job reluctantly and even unwillingly. For the most part he has had no training in Scouting, and, far more important, he is more or less ignorant of the mental-hygiene aspects of adolescence. Often he accepts his job as his contribution toward the constructive program of his church or his community and entirely lacks any insight into the task he has undertaken or his own equipment for handling it. The intentions of such a Scoutmaster may be commendable, but his troop is not as a general rule successful.

Scoutmasters may fail because they are not aware of the necessity of obtaining this transference, or because they do not know how to obtain it, or because, having once obtained it, they cannot capitalize it. In the first case, they regard their job of Scoutmaster as a task to be got through and fail the Scout movement in proportion to their apathy. In the second case, they fail to lead; they look to their Scouts to educate them, to blaze the trail over which they themselves have never gone or even indicated their intention to follow; they expect their boys to be something different from themselves. In the third case, they may be highly successful as boy leaders, but because of their ignorance of, or apathy toward, the Scout program, their groups are rarely successful as Scout troops.

The effect upon a boy of a successful Scouting experience varies with many factors, but depends primarily on the type of Scoutmaster he has had. Assuming that he has progressed through the various Scout ranks to the highest, that of Eagle (as over 5,000 boys in the United States did

in 1927), he has probably come into contact with many psychological forces that he would have missed entirely outside of Scouting. Aside from the stated purpose of the organization—"to teach patriotism, courage, self-reliance, and kindred virtues"—which is successful in varying degrees, though difficult or impossible to measure, Scouting offers definite opportunities for mental-hygiene work with boys. Among these are the following:

1. *The development of life interests.*—One of the purposes of the merit-badge program is to serve as a guide to the boy in the field of pre-vocational study. Unfortunately or otherwise, this purpose is rarely fulfilled. On the other hand, the whole program lends itself excellently to the development of life interests and hobbies. The emphasis on nature study develops many devotees who carry on their interest in birds or flowers or trees long after they leave Scouting. This is occasionally true also of the Scout's interest in other merit-badge work—art, aviation, crafts of various types, hiking, marksmanship, photography, radio, taxidermy, and so forth.

In all such cases, the value of a creative avocation carried over from the Scouting experience into adult life is of inestimable value. Psychiatric study reveals almost universal introversion in schizophrenia and characteristic introspection in psychoneurotics. In a surprisingly small percentage of such cases has the individual ever developed an avocation. Consequently, if the Scout can develop any kind of lasting avocation from his contact with Scouting, the organization has contributed heavily toward that individual's mental health.

2. *Dexterity in masculine accomplishments.*—The Scout program teaches as a matter of routine many very desirable activities that are distinctly masculine in their natures. Proficiency in feats such as fire building, the use of knife and hatchet, knot tying, swimming, and the like, is desirable for every boy—and for every man—and Scouting admirably includes them and many similar activities in its program. The psychological result is apparent. Every Scout is more or less aware of this advantage and develops a sense of con-

scious pride in his accomplishment. Particularly is this point of value in the case of the effeminate type of boy; his Scout accomplishments tend to counterbalance his feminine attributes and focus his attention on further masculine efforts.

3. *Socialization.*—As stated above, the development of group interest and consciousness is a psychological factor that contributes heavily to the success of the organization. It has, moreover, a good result in the way of educating and influencing the schizoid personality toward a more healthy social extroversion. Undoubtedly many seclusive and asocial boys are tremendously helped by being required to participate in patrol and troop undertakings, and an even larger class of boys are benefited by their introduction into and their development of a group consciousness. They are impressed with the idea of "making good" for the sake of the whole patrol or troop and with their responsibility as individuals to contribute to group success. Joining a Scout troup is often the first occasion on which a boy is obliged to adjust himself to working harmoniously with other boys, and Scouting offers an excellent opportunity for him to develop this ability. If ideally conducted, the program gives the older boys the responsibility of helping the younger boys, so that a Scout's rôle gradually changes from that of a student to that of a teacher and from that a follower to that of a leader.

4. *Group enforcement of standards.*—The Scouting program admirably outlines an ethical code of high standards. Whether these standards are carried out in the small group depends largely on the Scoutmaster. The enforcement, however, if successful, is almost entirely in the hands of the group. When successful, the mental-hygiene effect on the individual is of tremendous advantage. The group forces him to be neat, to be snappy, to be interested. It compels him to conduct himself within approved limits. It establishes a moral tone and enforces it upon its members much more effectively than any one single opinion could. This self-enforcement of an admirable code during the formative years of adolescence is of exceptional value to the subsequent mental health of the individual.

5. *Emulation of the leader.*—Probably the most fruitful opportunity for mental-hygiene work in Scouting lies in the guidance given by the Scoutmaster to his Scouts. In the ideal troop, the Scoutmaster holds a place in the Scout's admiration and affection second to no one except perhaps the boy's own father. As a result, the Scout seeks and accepts the advice of his Scoutmaster during a period of development when, were it not for this contact, he would probably be without confidential adult counsel and advice. At an age when the family's influence on the boy is beginning to wane, his admiration for his Scoutmaster will lead him to emulate this leader in many ways. Depending, of course, on the amount of transference established toward the Scoutmaster, the Scout will accept his leader's ideals and standards and opinions. He will form his likes and dislikes after the model of his leader and formulate his approval and disapproval as his leader suggests. The opportunity for the Scoutmaster to play the rôle of mental-hygiene counselor is unexcelled, and in fact he often does so, for better or worse as his equipment and training permit. By obligating its leaders to subscribe to the Scout oath and laws, the Scout program protects itself, and unquestionably the general result is decidedly beneficial.

SUMMARY

The Boy-Scout movement is one of the most powerful and probably one of the most effective programs of mental hygiene for the adolescent boy. The psychological methods that contribute largely to its success include conspicuously the gratification of the ego desires, the development of a group consciousness, the direction of the boy's egoistic libido into purposeful, creative paths, and the transference established with the Scoutmaster. The more important beneficial mental-hygiene results accomplished are the introduction of life interests, the acquisition of proficiency in strictly masculine accomplishments, the development of group sociability and coöperation, the group enforcement of moralistic standards, and the emulation by the Scout of his leader.

PSYCHIATRIC SOCIAL WORK, ITS NURTURE AND NATURE*

HELEN L. MYRICK

President, American Association of Psychiatric Social Workers; Executive Secretary, Illinois Society for Mental Hygiene

"PSYCHIATRIC social work"—those three words have such different connotations for different people. At one time not long ago, in a discussion of the problem of persuading a municipal body to employ social workers, it was suggested that the difficulty might be solved by recommending psychiatric social workers. The chairman of the committee, a leading educator in the social-work field, immediately vetoed the suggestion, explaining that the type of individual to be dealt with was not the feebleminded, but "ordinary normal people". This attitude and that of the present-day social and health agencies which are employing psychiatric social workers in an advisory, educational capacity represent the two extremes of opinion with regard to this comparatively new development.

These points of view reflect the trend of the times not only in psychiatric social work, but in the field of mental hygiene also. The progress of the mental-hygiene movement resembles that of the public-health movement. First came study of and improvement in the care of the mentally diseased and defective and popular education in regard to the significance of these conditions. During this period after-care work with paroled patients from state hospitals and increasing realization of the significance of social behavior in determining diagnosis, prognosis, and treatment led to the establishment of psychopathic hospitals for the preliminary study of patients before they were either committed to state hospitals or allowed to return to their homes. At this period the psychiatric social worker as such came into being through the foresight and efforts of Dr. Ernest E. Southard and Mary C. Jarrett at

* Presidential address before the Annual Meeting of the American Association of Psychiatric Social Workers, Memphis, May, 1928.

the Boston Psychopathic Hospital. This led to the establishment of the first course in psychiatric social work at the Smith College School for Social Work.

Psychiatric social work has been an integral part of the mental-hygiene movement since its inception. With increased attention to social behavior, it became apparent that it was necessary not only to treat and care for the mentally ill and defective, but also to carry on preventive work with children. Clinics were, therefore, established to study behavior problems in juvenile-court cases. Child-guidance clinics for the service of communities, habit-training clinics for young children, and mental-hygiene units in schools, colleges, and industries are among the more recent developments.

Not only in the clinical aspects of mental hygiene has psychiatric social work played an important part, but in the educational aspects also. Of course case-work implies the education of members of the family, advice to other social workers in regard to their cases in a clinic, social interpretation of the medical findings, advice as to the personality data required for examination, and so forth. A few selected clinics also carry on field training of students in psychiatric social work at professional schools and offer undergraduate students and others opportunities for vocational observation and for the collection of data for theses. Talks to mothers and other groups are given by clinic workers on the social aspects of case-work.

Community organization, propaganda, and the technical training of general case-workers and public-health nurses in the various aspects and applications of mental hygiene as a preventive measure for *all individuals* are other activities that have been carried on by psychiatric social workers during recent years. These things have been done not as part of clinical work, but in connection with state societies for mental hygiene and family-social-work and public-health-nursing agencies. The question arises whether this type of work is primarily psychiatric social work. It is apparent that the training of the psychiatric social worker in the technical application of the principles of mental hygiene and her education in sociology give her an equipment peculiarly suited to the work of organizing the social forces in a community for fur-

thering mental hygiene and of applying mental-hygiene principles to various forms of group thought—nurses, educators, parents, and others. Does she, however, need the special equipment she has in social case-work? Again to make comparison with the physical-hygiene movement, we find that in the early days propaganda, exhibits, and other forms of popular education were conducted entirely by physicians and nurses. Now, however, practically all of this type of work is being carried on by laymen. Possibly in the future a mental-health worker will be developed who has not the specialized training of the psychiatric social worker, the psychiatrist, or the psychologist. But such a worker in the general educational field of mental hygiene would not be equipped to train the family case-worker who is on the job in the mental-hygiene aspects of social case-work. This work at the present time requires rather a special educational technique which has been developed by psychiatric social workers employed for the purpose by family-welfare agencies.[1] This form of teaching is desirable and necessary at the present time when there are many social case-workers in other forms of case-work who were trained before the theory and technique of mental hygiene and psychiatric social work were included as a minimum requirement in professional courses. Even now this requirement is made only in one or two of the more progressive schools. Eventually, when all social workers have had this specialized training, the present practical method will no longer be necessary.

II

In spite of the increasing use of psychiatric social workers by social-case-work agencies for the education and advice of their workers, leaders in the family-case-work field are asking in what way does psychiatric social work differ from other forms of case-work. Is it not merely an administrative differentiation rather than an intrinsic, technical one? they ask, as well they may. Here is a new development growing, not out of the social-work field, but out of the mental-hygiene field,

[1] See the 1923 Annual Report of the Illinois Society for Mental Hygiene for an account of an experiment carried on in coöperation with the Chicago United Charities.

using case-work technique, but claiming that it is different. To add to the confusion in this curious new growth, there appear to be various concepts and techniques which are not identical within the group of psychiatric social workers themselves.

Where do we actually stand on these questions? It is an accepted fact, I think, that the practice and definition of psychiatric social work varies according to the school of psychiatry in which the psychiatric social worker has been fostered and is working. Those who are associated with psychiatrists of the psychoanalytic school, for example, as a rule seem to consider their social work merely an extension of the psychoanalytic technique to the patient at home instead of at the clinic. They do not distinguish between social-case-work technique and the psychiatrist's technique. On the other hand, psychiatric social workers trained in more eclectic schools of psychiatry, while they may use the same type of psychological approach as the psychiatrist, use it for the purpose of helping in the individual's outside social adjustments, leaving the inner adjustment of personality to the psychiatrist. This type of worker sees the technique of social case-work as distinctly different from that of the psychiatrist. She feels that it is her business not only to obtain data on the social behavior of individuals for the psychiatrist's use and to assist the patient in his social adjustment, but also to discover and cope with all the social problems in the family of the patient.

In spite of these marked differences in approach, which I have roughly indicated, there are essential basic similarities, and it is these that intrinsically differentiate this form of social case-work from other forms. There are, of course, also elements which show that it is a form of social case-work. In the first place, in psychiatric social work the approach to the individual is that of mental hygiene. The worker considers and deals with social adjustments, whether of the mentally ill person or the well person who is having unusual emotional difficulties, always in the light of his behavior and his apparent potentialities for mental health. Her special technique consists of her form of study of social behavior and her methods of dealing with personality, environmental factors, and persons in the individual's milieu in such a way as to

create understanding of causes and motives of behavior, to arouse incentives, and in every possible way to assist in her client's *psychological adjustment within his social life.*

Another important factor in this field which all psychiatric social workers seem to agree upon fundamentally is the point of view or philosophy of mental hygiene which, stated briefly, is the non-condemning, objective approach to all behavior, attitudes, and human relationships. On the administrative side, the approach is always through or in close coöperation with a mental-health unit or agency, and case-work and educational work are conducted as an integral part of a general program of mental health.

It is difficult to define clearly the intangible qualities of an art, especially one so evanescent as psychiatric social work. After reading these statements of differentiating elements, the family case-worker and others might justifiably say that they consider all these in their work. Fortunately, up-to-date social workers are discussing their ideals and standards from the angle of development of personality. Also, many of them are now equipped actually to practice case-work from that angle. The fact remains, however, that the vast majority are not as yet so equipped, even though they may have enough theory to discuss their work from this angle. It is this discrepancy between abstract knowledge and ability to apply it which at present largely prevents these workers from doing work similar to that of the psychiatric social worker. It will take a long time for the approach, the objectives, and the philosophy of mental hygiene as indicated above to permeate and displace the present primarily economic, legal, or health approach of the average non-psychiatric social case-worker.

Little has been said here of the methods of social case-work that have been taken over by the psychiatric social worker from the family-case-work field. The general methods of social investigation, social diagnosis, use of social resources, and case recording, and the application of sociological principles, economics, physical-health standards, and socio-legal facts have all been accepted and adapted by the psychiatric social worker in varying degrees. It is because of this that the fundamental differences are difficult to define. It is needless to point out the obvious fact that if social case-work had

not been developed so fully as it had been in its oldest form, family social work, psychiatric social work would have been infinitely slower in its inception. Because of the youth of this new adaptation and the emphasis on its mental-hygiene aspects, the use of the older tools of social resources and financial and legal aid are frequently neglected or not used to the best advantage. Psychiatric social workers are becoming aware of this and are now attempting to get this equipment.

III.

What, then, are the techniques used by the psychiatric social worker in "her form of study of social behavior and in her methods of dealing with personality . . . and helping with a person's psychological adjustment within his social life"? This is the crux of the question. As yet, in this specialized art of social case-work, there are not enough uniformly prepared data from which to draw conclusions. In the form of study of social behavior, the techniques are not especially new although the emphasis is different. In the matter of social treatment, however, the techniques of the psychiatric social worker are far more conscious and specialized than in other forms of case-work. Various case studies, such as *Three Problem Children* and *The Problem Child in School,* give examples of techniques, but much is left to the imagination even in these excellent reports. Most studies in this field deal with social aspects of behavior, the effect of the environment on later adjustments, rather than with the art of the psychiatric social worker.

The American Association of Psychiatric Social Workers, which now has a membership of about 205, has been studying this question during the past two years. Eventually their findings will appear. Other topics, such as education for this field, relation to other institutions and agencies, and standards of work, are all receiving the active attention of the association. As a suggestion for study topics, the president this year analyzed the various aspects of psychiatric social work and sent out the following suggestions to the local groups of the association. In order to make the program complete, she included the aspects already being actively studied as well as those not yet approached.

Suggested Program for Study

Psychiatric-social-work processes.—At present the association has a *committee on treatment* which ideally would cover such subjects as technique in interviewing; the application of mental hygiene and social treatment; the correlation of the psychiatrist's findings with the psychiatric social worker's methods; the study and treatment of the patients' social interests, such as recreation, education, economic interests, and the like. Besides treatment, the *social history* and *methods of social analysis and diagnosis* might well be studied as separate subjects.

Relations to other sciences.—In psychiatric social work the question constantly arises as to our relationship to psychiatry, sociology, psychology, industrial economics, anthropology, biology, and other sciences which we correlate in our work. The two most closely related at the present time are psychiatry and sociology. In psychiatry, the psychiatric social worker functions somewhat differently with each school of psychiatric thought represented in the various clinics. It might be profitable to study these differences in approach and technique, and also to study the general professional relationship between the psychiatrist and the psychiatric social worker in clinical work. Sociology and our relation to it is becoming more and more an acute problem, particularly psychological sociology, in vogue in some universities and practiced in the community by graduate students. Cultural backgrounds, community organization, and other aspects of sociology are necessary to our work. It would be of interest to see just how consciously we are applying our knowledge to our case-work and how much we are contributing to sociology. The same kinds of problem occur in relation to other sciences and offer limitless possibilities for fruitful study in the future.

Relation to other fields of social work.—The similarities and differences, points of contact, and methods of coöperation with other fields of social work—medical, family, group, child-placement, probation, and visiting-teacher—are being constantly considered by psychiatric social workers in their daily work. Systematic study might help us to formulate our ideas and to profit by a closer correlation between these fields.

Community relations.—Each year sees mental hygiene organized in more states through the formation of societies for mental hygiene and in connection with health and social agencies, schools, colleges, churches, court, child study, and social groups. Psychiatric social workers are being used to carry on this broader community education because of their sociological training, as well as their technical knowledge. With this broadening of their function arise many questions in regard to method of work, professional standing, and the maintenance of technical skill in case-work.

Education and placement.—The association since its beginning has had an active committee on various phases of these subjects, such as academic courses for psychiatric social work in professional schools, supervision of field-work training, advanced education of psychiatric social workers, supervision of staff workers, education of social workers in other fields, placement, and pre-vocational guidance in psychiatric social work. This year emphasis is being placed on the last four phases.

Professional standards.—A committee on this subject was appointed in June, 1927, to carry on work already started on psychiatric social work in relation to general hospitals, state hospitals, and the United States Government Veterans' Hospital and Federal Reclassification Board; also to consider other subjects such as fees for psychiatric social work, prerequisites for practice in our field, salaries,

and working conditions. This committee will coöperate on questions relating to standards with the membership committee and the committee on education and placement.

Very active work has been carried on by the various subcommittees of the standards committee, the newest development being the study of private psychiatric social work. Published reports of the need for psychiatric social work in state hospitals are to appear soon. Under the heading "Community Relations", an energetic committee on psychiatric social work in educational institutions has gathered interesting data on aspects of this new use of the psychiatric social worker. Some of this material will be presented at the open meeting of the association at this annual meeting—1928. The membership committee is studying the intricate question of membership requirements. This has involved careful consideration of the term psychiatric social work, courses in psychiatric social work, and standards of performance.

The committee on methods of psychiatric social treatment is conducting a round-table discussion on the subject at this meeting. Another round-table discussion is being held on psychiatric social work in relation to the work of social agencies. One local group has taken for its year's work the question of the social attitude of the family to various aspects of behavior, such as at school, habits, recreation. In this way the suggested program for study has been followed in part.

In the association are to be found psychiatric social workers in all fields of mental hygiene. They are in schools, social and health agencies, community clinics, traveling clinics, state hospitals, general medical dispensaries and hospitals, mental-hygiene societies. The members also vary in their approach to their work, some having studied in the psychoanalytic school of psychiatry. It is of extreme importance, therefore, that they meet for study of their mutual interests. The possibilities for research and for the development of effective techniques, the conscious use of theory, the development of educational methods are limitless.

The future development of this form of work rests with the association. It will of course always be influenced by developments in psychiatry and mental hygiene and also by sociology and social case-work. Upon the professional social-work

schools will depend the quality and equipment of psychiatric social workers. What the future actually will bring can only be predicted. It is possible that the techniques and approaches of psychiatric social work will be practiced in the entire social-case-work field. Psychiatric social workers as such would then limit their work entirely to research in technique for the use of practicing case-workers. In whatever way we go, it is important that we always bear in mind all of the intrinsic qualities of psychiatric social work.

SUMMARY

To sum up, we see that psychiatric social work was developed as an entity in the field of mental hygiene, having the mental-hygiene approach and point of view. It has adapted the principles and methods of social case-work to meet the socio-psychological needs of individuals. Its techniques are now beginning to be consciously studied and formulated. Its general methods of social investigation, social diagnosis, and application of case-work principles are similar to the methods used in all case-work. However, the *way* in which it makes these applications and conducts social treatment differs essentially from other types of social work. For this reason family-case-work agencies are beginning to employ psychiatric social workers as advisers on their staffs as a means of helping them to make practical applications of mental-hygiene principles in all their work.

There are marked differences in the conception of the functions of a psychiatric social worker among our own group, due apparently to the influence of the various schools of psychiatry with which the workers are associated. However, the essential distinguishing qualities of point of view, approach, and philosophy are agreed upon. The Association of Psychiatric Social Workers serves as a meeting ground for the study of the various factors in this specialized art. Different points of view are represented in the membership of the association and the future development of this field of work depends upon the amalgamation of ideas and the concerted effort of the members. Future developments in mental hygiene and social case-work and the type, theory, and training given by the professional schools are also determining factors in its future.

THE BERKELEY COÖRDINATING COUNCIL

VIRGIL E. DICKSON
Assistant Superintendent of Schools, Berkeley, California

THERE are several agencies in every community that deal with the guidance and control of youth. Often two or more of these agencies work on the same case, each ignorant of what the others are doing or have done. This is not only wasteful of the time and energy of the agencies concerned, but often is actually harmful in its results on the individual under treatment. If any community is to concentrate effectively its efforts for the treatment of problem children, it must have the unselfish coöperation of all the agencies that have to do with child life. When a problem arises, there should be centralization of information and effort. Each agency must be willing to surrender prerogatives or to accept additional responsibility if the case seems to demand it. All must unite in their willingness to serve in the way that seems best for the guidance of youth and the betterment of the community.

It was to foster this spirit of coöperation in Berkeley that the executives of the police department, the health department, and the Bureau of Research and Guidance in the schools met in the year 1924 to discuss ways and means for a better coördination of our work, especially with reference to salvaging maladjusted children. The group met informally several times; then effected an organization, elected a chairman and secretary, and planned regular weekly meetings. The organization chose for its name "The Berkeley Coördinating Council for Child Welfare". The aims and purposes were stated as follows:

1. To promote the physical, moral, and mental welfare of the children in the community.

2. To coördinate the activities of existing agencies, preventing duplication.

3. To promote personal acquaintance and *esprit de corps* among executives of the various agencies.

The membership of the council has been extended until it now includes the following workers: the city health officer, the superintendent of social service of the health center, the executive secretary of the Welfare Society, the agent of the Charity Commission, the visiting teacher, the director of elementary education, the chief executive of the Boy Scouts, the policewoman, the chief of police, and the director of the Bureau of Research and Guidance of the city schools.

Studies are constantly under way to reveal those conditions in the city which are responsible for maladjustments in children. Also, we seek to know and to encourage activities that contribute to the shaping of a desirable character and personality. We realize that in encouraging the factors that make for good in childhood we serve the same cause as we do when we reduce the power of the agencies that stimulate the bad.

I will mention just a few of these studies in order to illustrate the nature of our work.

A master list has been made showing the names of all youths who have been brought to the attention of each of the coöperating agencies. This list is so arranged that it is possible to tell at a glance which of the agencies have dealt with each child and the cause for which he was reported to each. In many instances two and sometimes four or five different organizations had been dealing with the same problem each in its own way—blindly so far as the rest were concerned. Now a glance at the chart, when a child is brought in, reveals what other organizations may have valuable information with regard to his development, and a telephone call will bring the history of the case and prevent unnecessary duplication. Often the cumulative record for years gives a scientific basis for guidance that would have been impossible on the basis of the brief data associated with the immediate cause for attention.

Spot maps have been made showing the location of the homes of all cases of truancy and delinquency. These some-

times show a focus of infection or contagion that, when followed up, reveals the influence of one individual or a gang on several others who are easily led.

Other lists show the names and addresses of children of very low mentality—those who need supervision or institutional care. Such individuals are always actual or potential problems for the community.

We have listed also the names of all children in elementary and junior high school who are two years or more retarded in school progress. It is well known that retardation is a symptom of trouble. A cumulative case history is being complied for each of these children. In many instances the history brings to light causes of trouble that can be removed. In other cases we find factors that, had they been known and properly adjusted two or three years ago, would have saved much trouble, but that now exert an influence apparently impossible to curb.

How does our Coördinating Council function?

Typical problem cases are discussed in our weekly meetings, and each is assigned to the agency that is in the best position to serve the case. When this agency has finished its work, if more needs to be done, the case is passed on, with all the pertinent data, to the next who can serve, thus avoiding all duplication of effort.

Soon we discover what routing of such cases is best and thereafter that procedure is followed without delay. Always we are seeking the coöperation that will be most effective and most economical of time and effort. Now when a problem case confronts any member of our working force, he knows immediately to whom he should appeal for first contact and support.

Each year we ask the teachers in all the public schools to report to us significant data and the history of every child (1) who is a serious problem in school, or (2) who has some special ability, interest, or aptitude. We define a problem child as one whose behavior varies from the average to such a degree that he cannot adjust himself readily to education in the normal groups in school. The following types of behavior are listed, suggesting the fields in which difficulties

are commonly found: retardation, truancy, sex difficulty, stealing, fighting, lying, nervous instability, cruelty, reticence, or any behavior that deviates from the normal.

The teacher is asked to check whether the problem is present in (1) minor, (2) exaggerated, or (3) abnormal form in any one or more of the ten fields mentioned above. She is also asked to give other significant data on each case.

For the reporting of children who show special aptitudes or abilities, the following suggestions are printed on the blanks: A special ability may (1) be general; (2) involve leadership; (3) embrace a special gift or talent. It may reveal itself in such lines as social activity, literature, science, mechanics, acting, art, music, athletics, and so forth. The teacher is requested to write fully describing the nature of the special ability.

These reports from the entire city are made the basis of a follow-up study by the Coördinating Council through a traveling clinic. This clinic, composed of a psychiatrist, a physician, a psychologist, and a trained social worker, visits each school and works with the principal, the teacher, the parents, and the child. When the school and the home are coöperative, there is the greatest possible chance of reaching problem children at a time when the difficulty is in its incipient stages and when preventive work is most effective. Service rendered at the school is acceptable to parents who would rebel at sending a child to the health-center clinic. Free service furnished at the school seems to produce a very different reaction from free service given at a charity center.

With systematic records kept from year to year of all children who present special problems or abilities, we are building a basis for scientific conclusions that should make the research of our Coördinating Council most significant and far reaching within the next decade.

The question has often been asked, Will this coördinating plan work in other cities, large or small? I can see no reason why it could not be adapted to any city. Berkeley is now organized as one unit. A large city like San Francisco could be organized into as many units as desired, each unit serving its own district. It is purely a matter of coöpera-

tion and organization. Let me emphasize that the essential feature of the plan is the unselfish coöperation of all agencies concerned for the one object—the betterment of the life of the youth in the community.

The outline that follows is presented to show briefly some of the duties and activities of each of the organizations as they relate to child welfare. The outline for each department is very much abbreviated and is presented here merely as suggestive of the work done.

Health Education in the Schools

School nurses:
- Assistance in communicable-disease control.
- Detection and correction of physical defects.
- Health education of parents, teachers, children.

Dental hygienists:
- Examination and recommendation for all school children.

Director's office:
- Reports of health findings and recommendations to Bureau of Research and Guidance, police department, physical-education department, and all coöperating agencies.

Berkeley Health Center

Therapeutic services to those unable to employ a physician.
Preventive services through lectures, conferences, and immunization.
Child-guidance clinic.

City Health Department

Collection of vital statistics.
Communicable- and preventable-disease control.
Water, milk, food, and sanitation (same throughout city).
Coöperation with school, police, welfare department:
- By acting as field health agents
- By obtaining parental support for family plan when required
- By bringing to bear upon problem children the rehabilitation forces of educational, police, welfare, and character-building agencies
- By reciprocal notification of findings and recommendations to all coöperating agencies.

Berkeley Welfare Society

State aid for needy children:
- Orphans
- Abandoned children
- Illegitimate children
- Children of fathers who are incapacitated
- Juvenile-court children committed for dependency.

Group and individual conferences to work out plans with other social and health agencies for rehabilitation of families.

Bureau of Research and Guidance

Investigations and recommendations on all problem cases referred to central office by principal or outside of school agencies.

Surveys of problem children and children with special abilities and aptitudes.

Administration of tests to check on ability and progress of school pupils.

Classification of pupils or assignment to special classes on basis of needs.

Educational, social, and vocational guidance of all school children.

The Police Department

Investigation of complaints received by the police concerning:

- Juvenile delinquency
- Defective home conditions
- Defective neighborhood conditions.

Supervision of public places of amusement and other places where juveniles may congregate.

Supervision of delinquents and potential delinquents.

Promotion of development of:

- Community centers
- Character-building organizations
- Civic-betterment organizations.

Coöperation with health, school, and welfare departments.

Conduct of educational campaign dealing with causes and prevention of delinquency.

TO A GRADUATING CLASS OF GENIUSES

EARL D. BOND, M.D.,

Physician in Chief and Administrator, Department for Mental and Nervous Diseases, Pennsylvania Hospital

TO talk to you for even fifteen minutes is a task. If I were not a psychiatrist, I should not attempt it.

Each of you must have a gift, or you would not have been allowed to enter this college. Here for four years you have studied the ways of developing that gift and, of course, those of you who have been most successful have become most insecurely balanced. Your diploma waiting for you on this platform certifies that you are expert, proficient, and lop-sided; it assures the world that you are predisposed to greatness and to trouble. Your gift gives you a problem in balance that ordinary people do not have. The converse of this statement appears in a novel I am reading: "Una was the least clever and the best-balanced one in the family."

And then you, both by birth and training, are made different from most people. You need no argument to convince you of that.

On these two points the psychiatrist is able to speak. His patients are unbalanced and different from most people. Why mental patients are easily upset, and why certain barriers isolate them, ought to be of very practical importance to you.

One matter ought to be settled at once. Wouldn't it be better for you, immediately upon graduation, to go to a sanitarium and stay there? There you would find even conditions of life, tempered winds, helping hands to keep you steady. You would not realize your difference from the crowd, because you would not see it and would not have to do the things that it does. Bases for invidious comparisons would be absent. For a certain price you would find unending tolerance and sympathy. The world of common sense would be kept out, with the butcher and baker and candlestick maker who insist upon treating you as they do any one else. "The world well

lost." If you wanted to spend twenty years in writing a book, as a friend of mine did, with no expectation that any one would ever read it, you would have that privilege. You will recall that in the Middle Ages the artists sought the protection of the monasteries, with satisfaction all around.

But it is not until they reach the age of fifty that most artists see the advantages of sanitarium treatment. You probably choose life; your arms are cordially wide open to it, although you know that it has proved too much for most geniuses. Life has proved too much for most mental patients, too, and I want you to consider them for a while.

It is just this unescapable (except by sanitaria) business of living that mental patients have to teach. In their failures and successes, they always have been great teachers, but no one has been willing to stoop to learn from them. But how can we learn as much from people hopelessly right side up as we can from those who see the world from many different positions? Real teachers have a queer streak in them. Think of what Alice found "Through a Looking-Glass"—how much she learned "In Wonderland" as she ate the mushroom and changed sizes in a twinkling. That Lincoln in young manhood was abnormally depressed was a thing that let him enter into phases of human experience that were closed to his more steady contemporaries. Consider Mr. Hamilton's lines on the innocence of Father Chesterton:

> "Standing, in dangerous balance, on his head,
> He sees mad, lovely marvels round him spread,
> And wins, with wild feet menacing the sky,
> The artist's awful innocence of eye."

The things that mental patients have to teach gain value from the psychiatrist's universal observation that the more closely the normal and abnormal activities of human beings are studied, the more they tend to coalesce. Explain one and you explain the other. Mr. Gamalial Bradford, on one page of his *Life and I,* gives four quotations which make it appear that psychiatrists have found only special instances of general rules. He quotes Emerson: "There is one mind common to all individual men. Every man is an inlet to the same, and to all of the same." And Mark Twain: "I become more convinced that I and other men are alike, and that what virtues I have

are the virtues of others, while the vices of others are all to be found in me." And Voltaire: "With a little imagination and one's own heart, one may understand everything in humanity." And Sainte-Beuve: "One can get to the depths of human life without ever going out of one's self." To Mr. Bradford's collection we can add Heine: "I am tragedy, I am comedy—a beast, a devil, a god." And especially is there a wide "inlet" into the hearts of geniuses and common men through their neurotic and psychotic brothers.

Please do not think that a psychiatrist sees so much abnormality that he thinks every one is queer. Rather he sees the normal where others do not—sees normality not as a chalk line drawn for us, not as a strait and narrow gate through which to make other people walk, but as a very wide road, its hazy margins disappearing in the distance. Normality should have room for the American banker and the Mahommedan beggar. To be normal does not even imply being average. Let me give some illustrations of normal explanations and abnormal behavior.

A young woman on a central-Pennsylvania farm became so seclusive and so indifferent to her family and its interests that her father brought her to a psychiatric clinic. Here it was established that her "abnormal" behavior was a normal defense against a family in whom religious fanaticism had destroyed all sense of proportion. Withdrawal in this girl was a preliminary to contacts with normal people, whom she found first in a mental hospital.

Many boys in colleges have had to act "queerly" and unsociably to escape from being absorbed into frenzied athletic activities. They are sometimes so well balanced that they are isolated.

Dr. Fernald could see, as the less wise could not, that many "truants" were good boys running away from a bad school.

Which brings us back to the value that the study of mental patients has for everyday life. Mental patients are fighting your own battles for you, with some important changes in conditions. Your knight in the tournament wears an identifying color; he is all Sorrowful, or all a Daydreamer, or all Activity; there is no doubt about him, no halfway measures. In everyday struggles there is no such plain marking; a knight fights

under a dozen different colors and tries to deceive you and himself about what caused his success or defeat; a cloud of dust envelops the field, and you wonder what the fight was about. But the mental patient wears his heart on his sleeve; he stays under the same color, come what may; he carries his one quality to its logical conclusion. His unwillingness to compromise may lead him to disaster, but it allows the bystanders to know what happens when unalleviated unselfishness and unmitigated reasoning are carried to the extreme. In the confusion of modern life there still remain some allegories to guide us.

Of all the banners under which mental patients fight, perhaps the delusion is the most characteristic. Suppose we define it, with the hope that no one will look too closely at the definition, as a false belief due to disease. We know certain things about it; it is not a haphazard thing to the patient, but the outgrowth of some of the patient's needs; it is attached to and dependent upon an emotion, and we see that it disappears as the emotion recedes; it is carefully and desperately protected against information. It is a sign of a closed road. Its ultimate origin may be in ignorance and accident, but it rises superior to all the enlightened and valid arguments that can be brought against it. These important facts can plainly be seen in mental disease, but they can be applied elsewhere.

For one patient ruled by delusion there are hundreds of well people ruled by prejudice, and it can be seen that every word applied to delusion except the word "disease" may be applied also to your pet false beliefs. The sign, "Road closed", is plain enough. Mr. Crothers put a definition of prejudices into a definition of tact "as the ability to find out before it is too late just what our friends do not want to learn from us". Our friends fly to the defense of a prejudice with a passion ridiculously too great for the trifling issue.

Some prejudices are harmless, some are interesting and colorful, but others are always pressing us to injustice to our present-day neighbors. There is something repugnant to those who love freedom in not being able to decide freely a present issue, and in being forced to bring to it a decision founded upon some past event which has no bearing on the case. A man I know is trying to treat his companions justly,

but he cannot because he has always to take the part of the under dog; his attitude now is determined by his father's unfairness long ago.

Geniuses tend to have prejudices against the common herd, and the common herd tends to have prejudices against them. It is not hard to trace the origin of your false belief that the herd, the well-ordered life, and conventions are all inventions of the devil. Your parents, teachers, and playmates did not recognize your unusual gifts and tried to force you along standard paths at a pace set by almost the slowest of your contemporaries. If some authority is linked in your minds with a just anger at its foolishness, then all authority brings out that anger. Freedom cannot exist with a prejudice against authority; unless you are free to accept as well as to reject rules, you are a slave to something. The world has had enough spectacles of artists battering their heads against some law because, when they were children, some one spanked them for the infringement of a petty rule. Such spectacles are understandable, but none the less infantile and unedifying.

But while you geniuses have much to endure from common people, they in turn have much to endure from you. In some way or other they have to forgive your superiority. They have to watch you trampling over rules that they know are good for themselves. If genius is a "divine release from inhibitions", it must be very hard on the neighbors. They allow you certain privileges which you share only with mental patients or with children—to be peculiar in dress, to be open in speech, to be less ashamed of having emotions, to be impractical. And after all, the little excellencies of the many, the common habits of common people, form a basis and a demand for the sky-reaching towers you build. How far would a musician go in a country that had no musical instruments? What a satisfaction to Cèsar Franck, at sixty-nine, to think that some people were beginning to appreciate his music!

And as you prepare to leave these sheltered halls, it will pay you to examine the experiences that mental patients have had with emotions. What has been their training in emotional control? How does it differ from yours?

Every college graduate has received two contrasting edu-

cations—one for his special work and one for his life. You, for instance, began as children a reasonably consistent and well-planned schooling for your work. Simple exercises led to harder ones. From kindergarten to college there were graded lessons—not so well graded for you exceptional souls, but still showing order of a sort. And as infants you began another education, a training for loving and living with other people. As you look back, where is the order here? Where the grading? Where the curriculum? Mental patients help us to look back; they tell us that baby problems were brought to them in adolescence; that grown-up lessons came to them when they were babies; that there was no system in it.

In that intellectual schooling, which in comparison shows a remarkable consistence and progression, you found that the multiplication table, once learned, could be relied upon later; no one tried to pull it out from under you. In geometry no one tried to replace an early theorem by such a one as was proposed by an interesting boy: "Things equal to the same thing are equal to anything else." But in our emotional training attacks upon and substitutions for early theorems are being attempted constantly. The first lesson in the book says, "Mother love is everything good." Further along we find, "Mother love is the origin of all evil." An emotional attitude fixed in us by some bitter experience ought to be unlearned because it turns out to be mistaken. When John was a helpless baby, a woman let his feet freeze; John naturally wanted nothing more to do with women; he is now trying to unlearn his lesson.

The intellectual training of the artist, his technique, can be graded and passed. The diploma ready for you on this platform guarantees your success—in an Arcadia; it is seldom that intellectual ability and skill ever fail any one, once they have been present and tested. But to how many of you, to how many people in the world, can we give a diploma which will certify that they are emotionally grown-up and entitled to the privileges of independent people? Not to the jealous, the envious, the suspicious, for these people haven't passed third-grade requirements. Not to chronic worriers or drinkers. Not to the selfish and disagreeable. Not to the graduate of any

school who cannot eat a meal unless it is cooked by her mother. Not, Miss Nelson says, to John Ruskin, who at fifty-two was ruled by his mother, who had previously accompanied him to college and chosen a wife for him. Perhaps to Benjamin Franklin. Certainly to some college graduates who have taken special courses in a sanitarium, finding out, for instance, that it isn't wrong to be happy, or that it is well to establish some regular habits from which imagination can take flight and on which it can find a landing place, or to develop a capacity for independent and unprejudiced actions.

It will not do to call attention to the mental troubles to which all are heirs without suggesting what can be done to avoid or cure them. It goes without saying, if one has thought at all about the matter, that in general we must support schemes for better emotional training. We must get a plan into it. Undoubtedly some of the trouble comes from introducing a soft baby into a hard world, and some of it cannot be helped. But a soft baby has a wonderful capacity to learn which ought to call out in adults a corresponding ability to teach. Wherever long-distance plans have been tried, they have met with gratifying success, even when started admittedly rather late. The person to whom a mother gives the care of an infant should be some one with better intelligence, training, and taste than her own. If we feel humble enough about our adult teaching ability, we have taken one step ahead.

Methods of reaching the prejudices of everyday life are fortunately at hand, thanks to the experience with delusions. The avoidance of direct attack is fundamental; arguing fixes the belief. The discussion of the foundations of beliefs in general has a good effect. The indirect practical attack has been illustrated by Dr. Watson. The baby prejudiced against a toy rabbit came to accept it when it was introduced under pleasant surroundings, first at a far end of the room and then nearer and nearer. Of course it is difficult to manage such treatment in surroundings more complicated than those of the laboratory. But it seems to me that many people who years ago protested against modern dress have been cured in some such manner, and it might be suspected that some one had been arguing with those not yet reconciled.

Another indirect attack is the occupational. The wished-for outcome is illustrated by the remark, "I was so interested in working for them (or with them) that I forgot that I did not like them." This policy is broadened in an effort to get prejudiced persons into the habit of making new mental combinations all the time. New interests and ideas as they change seem to make old sets, old attitudes, change in sympathy—or to drain off some of the emotion that is behind the prejudice.

If one were trying, for some selfish political end, to intensify the prejudices of a community, one would argue about them, pro and con, while encouraging idleness, provincialism, and the settled habits of a premature old age with its unwillingness to consider new ideas.

There is a longer and more difficult remedy for prejudice and uncontrolled emotions to be considered—the attempt to run to earth the past experiences that keep you happy, or unjust, or jealous— that keep you from being "free and twenty-one". It consists in a laborious review, with doctor and patient working together, of that curious mental life of ours which runs alongside of our more sensible thinking—where dreams, superstitions, and symbols run riot. It means trying to recover and to uncover events of childhood which we handled badly, or solved at a fairy-tale level—to live them over again in the light of our adult experiences. This is psychoanalysis, long and expensive—eight weeks at the least and years at the worst—applicable to some people and some situations and not to others. Many of its difficulties are evident; we have forgotten so many of the origins of our attitudes, our fears, and our conclusions, and the further we go back, the harder it is to find the right words—for our words have changed with our times. In all this exploration mental patients are of great help; they are almost "contemporary ancestors" of ours; they often get directly to a life and thought hidden from well people; they are what we were; they can tell us how differently their minds work when they are sick and when they are well. And psychiatrists, after analyses, after the study of mental diseases, may make suggestions for the better guidance of everybody's education and problems, so that many can gain without paying the cost, either of a struggle to get at what they do not wish to face or of mental disease.

But can I see geniuses going into the world without asking them to give a thought to these things? Psychiatrists play a small part in the world; but I hope that you see why psychiatrists must do two things—look after their patients and pass along the lessons learned from them to the most normal and most gifted people they can find.

PROBLEMS PRESENTED AND RESULTS OF TREATMENT IN 150 CASES SEEN AT THE HABIT CLINIC FOR PRE-SCHOOL CHILDREN IN BOSTON *

SYBIL FOSTER

Chief Social Worker, Habit Clinic for Pre-school Children, Boston

DOROTHY STEBBINS

Habit Clinic for Pre-school Children, Boston

THIS study was undertaken with the purpose of determining what problems confront us most frequently. We hoped to learn, if possible, the results of the treatment outlined, and in this accounting to draw conclusions as to the causes of success or failure that would help us in formulating further plans for individual therapy and in the general development of our work.

The 150 cases reported on in this group were selected from the first 300 seen in the Habit Clinic in Boston. All of the cases had been known to us for two years, and in some instances five years had elapsed since our first contact. Some of the 300 had to be eliminated because there was too little information on them to be of value in this study, while, in spite of careful search, many of them could not be located. This follow-up study after a period of years was a particularly difficult task because of the fact that in the early days of our development, our intake of patients came largely from the thickly settled tenement districts where the population shifts rapidly and where contact with the families is easily lost.

To obtain the information with which to check up progress, a visit to the home was made in each case. The purpose of the study was explained to the parents and the facts were brought out by direct questioning. In every instance an

* The material used in checking up progress in these cases was obtained by Miss Dorothy Stebbins in 1927.

TABLE 1.—CLASSIFICATION OF PROBLEMS PRESENTED IN GROUP OF 150 PRE-SCHOOL CHILDREN.

Type of problem	*Number out of 150 cases.*	*Satisfactory improvement when clinic contact ceased.*	*Unsatisfactory improvement when clinic contact ceased.*	*Satisfactory at time of follow-up.*	*Unsatisfactory at time of follow-up.*	*Short-time case.*	*Intensive case.*	*Physical environment*				
								Coöperative parents.	*Uncoöperative parents.*	No resources.	Fair resources.	Adequate resources.
Faulty food habits.....	61	26	35	33	28	50	11	30	31	11	42	8
Enuresis	56	32	24	43	13	40	16	38	18	21	34	1
Temper tantrums	50	12	38	20	30	35	15	22	28	20	29	1
Disturbances of sleep.....	34	17	17	25	9	24	10	20	14	12	21	1
Disobedience	27	10	17	14	13	19	8	13	14	10	16	1
Disturbances of speech.....	25	7	18	15	10	20	5	16	9	11	13	1
Masturbation	23	15	8	17	6	17	6	16	7	9	14	0
Thumb sucking	20	6	14	13	7	16	4	8	12	8	12	0
Pugnacity	15	3	12	7	8	9	6	7	8	6	8	1
Hyperactivity	12	2	10	5	7	6	6	4	8	2	9	1
Nail biting	10	7	3	8	2	8	2	8	2	3	5	2
Soiling	10	4	6	10	0	7	3	6	4	5	5	0
Jealousy	9	2	7	6	3	6	3	6	3	3	6	0
Crying spells	9	8	1	9	0	4	5	8	1	2	6	1
Overattachment	8	4	4	6	2	2	6	6	2	1	6	1
Irritability	7	3	4	3	4	5	2	2	5	2	4	1
Shyness	7	4	3	7	0	4	3	5	2	3	4	0
Fears	7	3	4	3	4	3	4	5	2	2	5	0
Destructiveness	6	0	6	1	5	2	4	2	4	4	2	0
Truancy	5	3	2	3	2	4	1	3	2	3	2	0
Excitability	5	2	3	2	3	3	2	3	2	1	3	1
Stealing	5	3	2	4	1	2	3	3	2	3	2	0
Lying	3	2	1	2	1	1	2	2	1	1	1	1
Negativism	3	2	1	2	1	3	0	2	1	1	2	0
Daydreaming	3	3	0	3	0	0	3	3	0	2	1	0
Limp spells	3	2	1	2	1	2	1	1	2	1	2	0
Personality change	2	0	2	2	0	1	1	2	0	0	2	0
Neurotic vomiting	2	2	0	2	0	0	2	2	0	1	1	0

attempt was made to learn the present status of the problems for which the child had been brought to the clinic and to discover to what factors the parents attributed their success or failure in dealing with these problems. The majority of them remembered the clinic experience well and were friendly and interested in the project.

In our effort to make clear the data obtained from the study of these cases, we have analyzed the material under the headings "Type of problem", "Satisfactory or unsatisfactory improvement", "Short-time or intensive case", "Parents coöperative or uncoöperative", and "Physical environment" (see Table 1, page 530). It seems advisable at this point to give some further explanation of these groupings.

Under "Type of problem" we have recorded 28 different kinds of problem, all of which appear more than once among the children seen. Some are the problems that caused their coming to the clinic, while others are those found after analysis of the case.

We found it necessary to record improvement under two subdivisions. The first is "Satisfactory improvement when clinic contact ceased". By this we mean a good response on the part of child and parent at the time contact with the clinic was closed, this response being definitely attributable to the advice and suggestions obtained. The second, "Satisfactory improvement at time of follow-up", refers to the status of the problem at the time of the follow-up visit, whether attributable to clinic contact or not. With the first group, some slipped back after contact ceased and at follow-up appear among those considered unsatisfactory, while some of those at first considered unsatisfactory later responded and appear in the satisfactory group at the time of follow-up. In no problem group, however, was the number with satisfactory adjustment at the time of follow-up less than the number at the close of the clinic contact. In the majority of instance, it was larger.

We call "short-time" cases those that involve less than five visits to the home by the social worker. "Intensive" cases are those having more than five social-service or clinic

visits and that may require repeated visiting in order to change attitudes and adjust the social environment.

The parents' response is listed as "coöperative" when sincere interest and effort are indicated. In the situation of a child with several difficulties, the parents may be entirely coöperative in dealing with one phase of behavior and utterly unwilling to work with us on another. This is given consideration, and coöperation is recorded in relation to the particular habit or difficulty, not to the situation as a whole.

Under the heading "Physical environment", the economic situation and physical condition of the home is considered and is classified as "no resources" within the home for normal growth and self-expression, "fair resources", and "adequate resources".

In Table 1, the various problems found in these cases are listed in the order of their frequency. This tabulation brings out some interesting material. We find that faulty food habits make up the largest group of problems, appearing in 61 of the 150 children under study. The proportion of improvement obtained is, moreover, rather low. Only 26, or 17 per cent, were considered satisfactory at the time clinic contact ceased, and 33, or about 55 per cent, at the time the follow-up visit was made. Of the 61 cases, 50 are in the short-time group, while the number of parents who coöperated and of those who did not are nearly equal. Under "Physical environment" an interesting fact appears—42 of these cases came from homes with "fair resources" and 8 from homes with "adequate resources". In no other problem are there more than 2 under the latter heading.

Neurotic vomiting was found only twice among the feeding difficulties, and each case cleared up early and maintained the improvement. Both were intensive cases, and the parents coöperated well.

Children with enuresis or incontinence of urine, either during the day or at night, make up our second big group. We find that 56, or 37.3 per cent, of the 150 had failed to establish dry habits and were, therefore, brought to the clinic. Improvement with this problem is decidedly more common than in the case of the feeding difficulties. When clinic contact ceased, 32 cases showed satisfactory improvement, and at

the time of follow-up, 43 had overcome the habit. The greater number were short-time cases. In just over two-thirds of the group was there good coöperation. An investigation of the physical environments of these cases showed that all but one came from limited and inadequate homes.

The problem of soiling appears less often, yet it seems logical to consider it at this time. We find the habit occurring in only 10, or .06 per cent, of the 150 cases. In 4 we obtained immediate improvement, and at the time of follow-up the difficulty had in all instances been entirely eliminated, even though 7 of the group were short-time cases. Good cooperation was given by the parents in 6 cases, and the 10 children came equally from homes of no resources and of fair resources.

The 50 cases of temper tantrums make up the third largest group. Only twelve of these were satisfactory when contact ceased and only 20 at the time of follow-up. Fifteen were intensive cases, and in 22 parents were coöperative. The environments, as in the case of practically all the other habits to be mentioned, are listed for the most part in the two least favorable classes.

We often find the child using crying spells and so-called limp spells as well as temper tantrums to express anger or to dodge an unpleasant situation. Nine of our group had frequent crying spells. Of these 8 improved at once upon treatment, and all had given up the habit by the time the follow-up visit was made. Intensive work was done with 5 of the cases, and in 8 of the 9 the parents were wholly coöperative. The so-called limp spells appear only 3 times, and 2 of these cases improved readily.

With the 34 cases of disturbances of sleep we obtained good results. Seventeen had improved satisfactorily when clinic contact ceased, and 25 at the time of follow-up, and this in spite of the fact that 24 were short-time cases. Parents were coöperative in 20 cases. Twenty-one of these children came from homes of only fair resources, and 12 from the most limited homes, where sleeping arrangements were congested and unsatisfactory.

General disobedience, or lack of training and discipline, brings us many children throughout the year. Twenty-

seven of the present group came for this reason. Ten responded immediately to the routine outlined, but only 14 were found to be improved at the time of follow-up. The greater proportion were short-time cases. Parents were coöperative in 13 cases and uncoöperative in 14.

Among little children we often find disturbances of speech. This problem came up in 25 of the 150 cases. At the time of follow-up, 15 had definitely improved. Coöperation was good in 16 cases.

Auto-erotic habits do not appear with great frequency in the group under study. Masturbation was observed in 23 cases, thumb and finger sucking in 20, and nail biting in 10. Suggested treatment for masturbation brought quick response in 15 cases; thumb sucking was decidedly slow to show progress, only 6 being improved when clinic contact ceased; while nail biting responded rather readily to treatment and, at the time of follow-up, all but 2 of the 10 cases had given up the habit entirely. Parents coöperated well in 8 of the 10 cases of nail biting and in 16 of the 23 cases of masturbation, but in only 8 of the 20 cases of thumb sucking was the advice given really carried out.

Truancy, stealing, and lying were rare in this group. Cooperation was good in these cases, and they responded well to the suggestions outlined.

Of the exaggerated personality traits, we see most often the pugnacious, hyperactive, excitable, irritable, destructive, extroverted type of behavior, yet in less than half of these cases did we get good coöperation from the parents and less than half showed ultimate improvement.

The introverted, shy, daydreaming, fearful, and negativistic child is brought to the clinic infrequently, but those that appeared in the group under study responded well. Of the 7 shy children, 4 improved while in contact and all 7 by the time of follow-up. Coöperation was readily obtained. The 3 daydreamers dropped the habit during an intensive and coöperative contact, even though 2 came from homes of the most meager type where substitution of interests was particularly difficult. The negativistic conduct changed after the carrying out of the suggestions given. With the fears of childhood, improvement was not so great. Of 7 children,

only 3 overcame their difficulties, though 5 parents were ready and willing to follow the advice given.

Jealousy and overattachments were found in 9 and 8 children respectively. In both these situations, improvement was good. Six of the jealous children responded to coöperative treatment, and 6 of the overattachments dropped back to apparently normal relationships.

Of the 150 children studied, only 2 appeared to have so-called "personality changes" subsequent to illness. Both of these made a slow readjustment; in both instances the parents were entirely coöperative.

From the material presented, we find, as might be expected with a pre-school group, that the problems we are most frequently called upon to treat are those relating to the establishment of the fundamental physical habits of eating, sleeping, and eliminating, and also those that develop during the general training and discipline of the little child.

Some may feel that these problems are of minor importance and will be outgrown, yet often we find the more spectacular and involved personality difficulties developing from these uncorrected simple situations. It is in the training for these first habits that the pattern of later conduct is laid, and the child early learns to adapt to a wise routine or finds that he himself can control the situation. Take, for instance, faulty eating habits. The difficulty is not that the child is having too little nourishment, but rather in the way he is using his caprices of appetite to terrorize the family into submission to his will. With enuresis, beyond the obvious unpleasantness of a wet bed, the habit may be far reaching in its effect upon the personality. If continued beyond normal babyhood, it stamps the child as different and tends to build up feelings of inadequacy and inferiority. Frequently the burden of the extra washing upon an already overtaxed mother so increases the emotional tension of the home that the comfort and happiness of the whole group is jeopardized. In the matter of discipline, if the child early learns respect for just authority, emotional control, and self-reliance, he should be well equipped to make the adjustments necessary when he leaves the shelter of the home and enters upon his larger community contacts.

Beside the major habit problems, we find somewhat smaller numbers of the various personality traits that are normal to all of us in some degree, but that have become exaggerated and are causing difficulty for the child in his social adjustment. It is quite evident, from this as well as from other studies of clinic material, that the child who comes to the clinic most often is the one whose extroverted tendencies have brought him into conflict with his environment. The passive, withdrawing traits cause little concern to the parents at this age and appear in comparatively few instances in this group of 150 children.

When dealing with personality development and modification of behavior, evaluation of results is necessarily difficult. In the case of the material under study, to take as an estimate of successful treatment the number of cases considered improved when clinic contact ceased would give us a misleadingly low figure. Parents often lose touch with the clinic before results could be expected from the treatment, and if evaluated at that point, the case would have to be considered unsuccessful; whereas these same parents, having obtained an outline of treatment, may consistently carry it through and definitely attribute their success to the help they gained from their clinic contact. In cases with longer contacts, improvement often comes slowly, upon the gradual assimilation and putting into operation of the advice received. On the other hand, if we take the number improved at the follow-up visit, we may have a somewhat inflated figure because of the lapse of time that has occurred. This time element must be considered, for we know that children pass through phases of conduct probably normal to their age, and the mere act of growing older has, in all probability, in some instances helped to eliminate the problem, as with a negativistic trend, mild masturbation, or thumb sucking. In general, however, the number that show ultimate improvement should be considered as the criterion of treatment success, for, if there has been a contact with the clinic, that undoubtedly plays some part in the recovery, even though the time element enters in as well.

Although we have considered our therapy adequate only when two-thirds or more of the children presenting a certain

problem have improved satisfactorily under treatment, yet in the case of 10 of the problems, we found decidedly more than two-thirds responding, and in the case of 5, all the children showed complete improvement.

Our greatest proportion of successes came with neurotic vomiting, soiling, crying spells, daydreaming, and shyness, all of which showed complete improvement at the time of follow-up. One may here ask why this particular group of difficulties should have responded in such a marked degree. Undoubtedly the emotional attitude of the mother plays a large part in the response in the case of the first three of these habits. They are spectacular, embarrassing, and annoying to the parents and arouse their concern and their desire to coöperate in a plan for treatment. The last two being passive and less irritating traits, it is rather surprising to find so large a proportion of improved cases. It seems only reasonable to suppose that the time factor has played a part here, particularly in the improvement of the shy children.

Enuresis and sleeping difficulties are the two largest groups to make satisfactory improvement. Enuresis is another unpleasant and inconvenient habit; parents are eager for help with it and considerable pressure is brought to bear to overcome the difficulty. With both enuresis and sleeping difficulties, a rather definite routine and schedule can be outlined, which makes the carrying out of instructions quite simple. On the other hand, with faulty food habits, the largest problem group, we find just over one-half of the cases showing satisfactory improvement, even though a clear routine is laid down for treatment. Two factors must be considered here. In the first place, physical gain is so closely related to intake of food that many parents become panicky and upset over the child's failure to eat three large meals a day, with the full quota of milk and vegetables, and the child is only too quick to sense this and capitalize it to his immediate advantage. In the second place, the mere waiting on the little child is often such a satisfaction to the mother that she may unconsciously cling to the child's dependence. The bottle is given longer than necessary, the child is spoon-fed instead of learning to feed himself, and a hard-hearted régime of pleasantly ignoring the child and removing the

uneaten meals with no comment may actually be beyond the parents' emotional ability.

The problems with which we have the least success in treatment are the feeding difficulties, as just mentioned, the extroverted personality traits — such as pugnacity, hyperactivity, temper tantrums, destructiveness, and disobedience— and the habit of thumb sucking. This last mentioned habit shows conspicuously both lack of success and lack of interested coöperation. Only rarely do the parents express great concern or show persistent desire to overcome the difficulty. In fact, we find children deliberately taught to suck their thumbs to keep them quiet, or encouraged to continue because they look "so cute".

With the personality traits, it is not surprising that we do not have a larger proportion of successes. For one thing, even with the professional group, the subject is not clearly defined as yet. Who can say what is inherent in the make-up and what is built up from without? Who can make a dogmatic prognosis as to the outcome if these traits are allowed to grow unchecked? We may theorize and speculate and probably may come fairly close to the mark, but we must be able to back up our theory if we are to convince parents of the ominous trend of some of the situations we see developing. Then, having convinced them of the need and won their desire to coöperate, we must be ready with a workable plan of treatment. Here, again, we find it difficult, for each situation varies; no easy routine suggestions can be laid down and results depend much more upon the parents' own initiative and resource. For instance, a hyperactive and destructive child may need freedom from restriction, plenty of muscular exercise, the development of new interests, and so on. Yet, if his setting happens to be more confining than the often desired "ten-acre lot", what then? Neighbors' property and rights must be respected, traffic and other dangers must be avoided, and usually the mother's attention must be divided among several children and the business of homemaking. It takes abundant physical energy and clever planning ability so to organize a situation of this type that the child will develop new interests, will have sufficient outlet without license, and yet that the home and the other children

will not suffer in the process. Like difficulties occur with temper tantrums and pugnacity. Often the simple treatment of allowing the child to shriek out his temper spells and obtain nothing thereby may bring the family a notice to vacate. Or if it is suggested that a pugnacious little rascal be allowed to continue his fights, in the hope that an attack upon a stronger child may teach him the lesson he so badly needs, the neighbors may rise up in objection and the parents may then feel that they must abandon the method, and yet lack the imagination and the originality to devise some substitute. More intensive work by the clinic staff, in explaining the need and in helping the families over a longer period of time to work out means to bring about the desired ends, would without a doubt raise the proportion of successes with these difficult and intangible personality traits.

The proportion of improvement made bears a close relation to the degree of coöperation obtained, as may be seen in Table 2. It seems evident that where a concrete régime for treatment can be laid down and where a marked emo-

TABLE 2. RELATION BETWEEN IMPROVEMENT AND COÖPERATION IN 150 CASES OF PRE-SCHOOL CHILDREN

Problem	*Total cases*	*Improved cases*	*Coöperative cases*
Faulty food habits	61	33	30
Enuresis	56	43	38
Temper tantrums	50	20	22
Disturbances of sleep	34	25	20
Disobedience	27	14	13
Disturbances of speech	25	15	16
Masturbation	23	17	16
Thumb sucking	20	13	8
Pugnacity	15	7	7
Hyperactivity	12	5	4
Nail biting	10	8	8
Soiling	10	10	6
Jealousy	9	6	6
Crying spells	9	9	8
Overattachment	8	6	6
Irritability	7	3	2
Shyness	7	7	5
Fears	7	3	5
Destructiveness	6	1	2
Truancy	5	3	3
Excitability	5	2	3
Stealing	5	4	3
Lying	3	2	2
Negativism	3	2	2
Daydreaming	3	3	3
Limp spells	3	2	1
Personality changes	2	2	2
Neurotic vomiting	2	2	2

tional factor in the parent-child relationship is not present, coöperation is readily given. The extent of the coöperation must necessarily depend upon interest, intelligence, emotional stability, and the physical and economic condition of the parents. We frequently find parents who are aware of their difficulties and apprehensive for the future, yet the sheer pressure of caring for a family on their narrow margin of income and physical energy makes them utterly unable to coöperate in treatment. On the other hand, we find parents who, in spite of almost overwhelming social problems, can carry out a treatment routine in such a way as to call forth our sincere admiration. We feel sure that if more time were given to the individual case, particularly by the social worker—who has an invaluable opportunity to interpret over and over again in detail in the home the recommendations given at the clinic—coöperation might be obtained in a greater proportion of cases, as failure to coöperate often means merely failure to understand.

This study includes cases seen in our first four years of development, when for many reasons we might have expected only a small degree of success. The Habit Clinic was started as an experimental project, the general public had little knowledge of the venture, and even the staff was unconvinced of the practicability of the plan. Our technique was in the making and only vaguely defined, and few routine measures were in use. The majority of our clients came from families already known to several other social agencies and presented the most involved economic and sociological problems, making the working out of a mental-hygiene program exceptionally difficult. Yet in spite of these handicaps, our therapy proved adequate for more than half of the problems we were called upon to treat. A study of cases taken from those seen in the last two years would unquestionably show interesting comparisons. As the work has developed, our confidence in our technique has grown and in many situations we now feel that we can safely be dogmatic in outlining treatment. Also we are reaping the benefits of the general educational work in mental hygiene. Many of our patients are now brought to us by parents who have heard or read of the service given and are seeking help; others come at the suggestion of those

who have already made a clinic contact; and a third large group comes through the efforts of workers in other social agencies who have an intelligent understanding of our purpose and explain it to the families before suggesting that they seek help. All this, of course, will make for better understanding of the treatment suggested and coöperation in carrying it through, and should greatly increase the proportion of improved cases.

We may, then, conclude from the facts brought out by this study that in the early cases seen, our therapy has been adequate with the greater number of habit problems. We do, however, need to develop more carefully our technique in dealing with the asocial personality trends. The key to the situation in each instance seems to be in coöperation, which in turn largely means understanding. Therefore, more time must be given by the staff to detailed instruction and the effort to make the treatment suggestions more clear and concrete. Especially, more of the time of the social worker should be available for intensive case-work. Above all we should develop our individual educational approach, for mental-hygiene work with little children must necessarily be that of parental education. We may at the clinic offer advice and suggestions based on our detailed study of the child, but it is our part also to make the parents understand the value of such advice before we can expect a satisfactory response to treatment.

ANTISOCIAL ATTITUDES, THEIR FORMATION AND REFORMATION

CAVENDISH MOXON

San Francisco

NOT long ago Freud startled the world by stating that criminal tendencies can be discovered behind the conscious surface of highly respectable and ethical persons. Freud was followed by Adler, Jung, and Stekel, who brought confirmatory evidence that criminals are made by the emergence and overstimulation of the same kind of tendencies that are inhibited by persons who had the good luck to live in an environment that favored the formation of socially desirable attitudes.

The contribution of these writers to the problems of the cause and cure of crime can now be studied in the translations of their books. But this is not true of the two most important contributions to our subject made recently in Europe. I refer to the work of Rank and Aichhorn, whose books have not yet been translated into English. Rank has made clearer the causes of antisocial behavior, and so makes clearer the way to prevent its formation. Aichhorn has shown how the most unpromising adolescent delinquents can be cured by a method built on the new knowledge.

In his *Outlines of a Genetic Psychology*[1] Rank shows the chief stimuli that cause the emergence of abnormally strong passions or emotional drives and criminal habits. In his *Neglected Youth*[2] Aichhorn shows how the already formed delinquent habits may be broken and replaced by socially safe behavior.

To take Rank's theoretical contribution first, it is the clearest account I can find of the genesis and growth of emotions or feelings. Rank traces the roots of love and hate

[1] See *Grundzüge einer Genetischen Psychologie*, and *Gestaltung und Ausdruck der Persönlichkeit*, by Otto Rank. Leipzig: F. Denticke, 1927 and 1928.

[2] *Verwahrloste Jugend; die Psychoanalyse in der Fürsorgeerziehung*, by August Aichhorn. Leipzig: Internationaler psychoanalytischer Verlag, 1925.

back to the time of earliest infancy. Freud saw that the first five years of life are the most important for the formation of character, but he stressed the later period from three to five years, when the father begins to take an important part in the making of the child's ego ideal. Like Watson in this country, Rank stresses the earlier period and the rôle of the mother and the nurse in conditioning healthy and socially acceptable emotional responses.

Some roots of later crime are found deep in the nursery period, in babyhood. At the school period it is too late to begin the search for the causes of antisocial attitudes. Even before the Œdipus phase, as Freud calls it, there is guilt and the beginning of an ego ideal. The child is innately built to respond to the prohibiting mother. Rank is compelled to assume an inborn tendency in the human being to check or inhibit innate impulsive drives. Too little inhibition means the prolongation of infantile irresponsibility to form antisocial or perverse activity; too much inhibition means neurotic ill health or waste of energy in ascetic self-torture. It largely depends on the parents', and especially on the mother's, behavior whether the child can avoid these morbid extremes of antisocial activity or passivity and develop a healthy capacity for love and work.

There are two ways in which the mother can promote healthy and socially desirable habits in the child. First, she can avoid an immoderate satisfaction of the child's love hunger and a needless arousal of resentment and hate. Second (if she is not too full of character kinks and emotional distortions) she can find the mean between the dangerous extremes in her discipline and training of the infant and child. "Spoiling" the child by too much love and leniency is less likely to produce crime than is loveless aggression or hypermoral coercion. If the child lacks sufficient external checks upon its impulses, it is apt to build excessive inhibitions in its conscience, often becoming neurotically self-critical. But if it feels too much the mother's prohibitions as hate, it may form the habit of resentful rebellion against authority and later displace this hate from its parent to its schoolteachers, to social restrictions, and to national laws.

We all know the relief we get by expressing emotion. It

makes us feel better, when enraged, to hurt something, even though the person or animal we hurt is not the cause of our rage. If anger and hate have been overstimulated in the child, it is often impossible for it to act these emotions out on its parents. Either it lacks the bodily or mental power to fight, or it also loves the hated tyrants, and so cannot get rid of its festering accumulation of morbid emotion. Consequently (as Rank shows) the child generally seeks relief for its pent-up feelings against mother, father, or rival child by means of aggression outside the family circle. Occasionally, indeed, the child kills its baby rival or even its parent, like Dorothy Ellingson, but usually it displaces its hate, like Hickman, from its own sister to the child of other parents, or, like Raskolnikov, to a mother substitute, or, like the anarchist assassin of royalty, to a father substitute.

The seeds of crime may be sown not only by really loveless parents, but also by really loving parents when they seem hatefully unkind to the child. This is not the place to give detailed information as to the latest theory of child training in habits of love and social adjustment. All I can do is to assure the reader that some very definite principles have now been worked out as a guide to parents and nurses in the difficult and delicate task of developing healthy emotions and socialized action patterns in the child. The inquirer is referred to an article by the writer in *Better Health*, December, 1928, entitled *Helping the Child to Bear Life After Birth* and to the pamphlets on the subject published by The National Committee for Mental Hygiene.

Here I may refer to another new and paradoxical discovery about the complex motives for crime. Some persons (as Reik shows in his book on the need for punishment) commit crime not only to get an outlet for hate, but also to get relief for an intolerable guilt feeling. A case of schoolboy naughtiness will serve to illustrate this strangely inverted mechanism as a factor in misbehavior. This boy was working with a psychologist for the purpose of getting an emotional adjustment. He confessed that at school he used regularly to do bad work in class and behave badly in order to be punished by his teacher. The teacher, knowing nothing of the boy's need, fell into his trap and spanked him

thoroughly. No doubt the teacher made a moral justification for his method of discipline which actually stimulated the habit of hate in the boy for the teacher and for himself.

This case leads me to the further striking evidence that Aichhorn has collected on this very point. As the principal of a reform school for delinquent adolescents of both sexes, Aichhorn had an opportunity to apply some of the new theories with regard to the emotional factors of delinquency. He was convinced that these wild, neglected, and antisocial youngsters had become delinquent through lack of love at home. He, therefore, decided to try the experiment of providing a substitute for home and for parental sympathy, understanding, and guidance. Accordingly he obtained as assistants teachers who were willing to avoid all corporal punishment.

This policy demanded an extraordinary amount of patience and perseverance, which came only from a strong belief in the correctness of the hypothesis to be tested. The youngsters tried in every possible way to maintain the habit of hate, aggression, mistrust, and rebellion against the authorities. To this end they made constant efforts to cause teachers and principal to lose their temper and answer their hate by hate, for violent disciplinary measures would have justified their continued revolt. But at length — the time varying according to disposition and intensity of emotion — Aichhorn's policy of sympathetic understanding and patient forbearance triumphed.

From several very instructive cases in Aichhorn's book I will choose two that show most clearly the emotional factors in antisocial attitudes and indicate the method of cure. The first is that of a thirteen-year-old boy who constantly stole from his mother and sister. This boy hated his mother for having had his younger sister, who robbed him of his power and freedom as the only child. His anger was increased when his mother seemed to love his sister more than him by giving her more money. To express his hurt and hate, he ran away from home, but his love made him seek cherries from his father's orchard trees to bring back as a guilt offering to his offended mother.

The second case is a young fellow who was sent to Aich-

horn because he used to steal from his very strict father. With the money thus gained, he used to give presents to his stepmother, who was not much older than he. The first interview with Aichhorn (part of which I reproduce) shows clearly the emotional need of the boy and the way in which it can be satisfied by one who has insight. In order to gain a rapport, Aichhorn asks: Do you know where you are?

The boy: No.

Aichhorn: In the office where adolescent cases are dealt with.

Boy: Yes? Yes, my father wants to put me in a reform institution.

Aichhorn: Your father has told me all that has happened, and I want to help you.

Boy: That is good. (*With a look of complete refusal and a shrug of the shoulders.*)

Aichhorn: If you don't want me to, then I surely won't.

Boy: You can't help me.

Aichhorn: I understand: you don't trust me; we are still too strange to each other.

Boy: I don't mean that, but it's no good. (*Again the same gesture of refusal.*)

Aichhorn: Are you willing to talk to me?

Boy: Yes, why not?

Aichhorn: I must ask you about various matters, and for that reason I am going to make you a proposal.

Boy (*in an expectant tone*): What about?

Aichhorn: To refuse me an answer to every question that is unpleasant to you.

Boy (*with astonishment and incredulity*): How do you mean?

Aichhorn: To the questions you don't want to answer, you may be silent if you like. You can also say to me that that is none of my business.

Boy: Why do you allow me that privilege?

Aichhorn: Because I am neither a judge nor a police agent. It is not necessary for me to know all. And because in any case you would not tell me the truth about unpleasant questions.

Boy: How do you know that?

Aichhorn: Because no one would do so, and you are no exception. I myself wouldn't tell everything to a man whom I had never seen before.

Boy: But if I speak to you and lie to you, can you tell that I'm lying?

Aichhorn: No; but it would be a pity to do it. And you don't have to, because I won't compel you to answer me.

Boy: At home they always said to me nothing would happen if I spoke the truth, but when I did, it always made matters worse. So I've accustomed myself not to talk.

Aichhorn: Here it is a little different. What you really wish to say will be enough for me. Certainly I must be sure that I shall not hear what is untrue.

Boy: Good.

Aichhorn: You agree, then? (*Holds out his hand to the boy, who grasps it strongly.*)

Boy: Agreed.

Having won the boy's confidence, Aichhorn was now able to discover the reason for his running away from home and stealing his father's money. His brother had been able to go with his mother to stay with an aunt abroad, while he had to stay on the job as a shoemaker at home. His father had given his brother some money for the trip. So he felt he had a right to take some money and give himself a trip as a compensation.

After interviewing the father, Aichhorn saw that the strict and emotional parent was unable to educate the emotionally hurt son. Aichhorn, therefore, arranged a series of meetings with the boy in the city. One evening, as they were walking towards Aichhorn's home, the boy remarked: "If my father behaved to me as you do, I should never have done all these things." The association was gradually broken off when Aichhorn saw that his aim was accomplished, and the father reported that the son was as good as ever before. Three years after that (at the time the book was written) no relapse had occurred.

Without love the reëducational process cannot begin. Sometimes Aichhorn was able to rouse the right attitude by means of an emotional shock. For example, a young narcissist only stayed in the institution when it seemed less pain-

ful than the world outside. This boy was uneducable for lack of what the Freudian calls a transference. One day Aichhorn purposely provoked the boy to run away. After nine days he returned, expecting punishment. Without even a reproach, Aichhorn looked at him and asked if he was hungry. Finding that he was famished, Aichhorn took him to his own dining table, but the boy was too amazed at the absence of hate in Aichhorn's attitude to be able to eat there. So he went to the kitchen. At ten Aichhorn remarked that it was too late for him to go to sleep with his group that night, and, stroking his head, offered him a couch in his home and wished him good night. Next morning the boy showed his belief in the principal as the "good mother" substitute; and soon after this his reëducation progressed so well that this thief and swindler could safely be trusted to bring an auto full of stores from Vienna to the school without stealing a thing. Later he did well in a big business establishment. Punishment would have fixed his hate in a life of continual crime.

One day Aichhorn had been reading Rank's theory and decided to test it on an eighteen-year-old thief. He put him in the tobacco store. The cashier soon reported a theft. Aichhorn called the thief into his study and asked him to help in dusting the books, and at intervals asked questions about his work. The boy's anxiety and suspense grew almost intolerable. Finally in answer to a direct question he confessed. Not a word of blame from the principal, who gave him the sum and told him to put it back in the cash box so that no one would know of his deed. The boy was so touched that he not only stole no more, but asked to be allowed to pay back his debt.

Aichhorn's policy demanded most patience with the small group of violently aggressive adolescents, who had all suffered from unloving parents and had been corporally punished at home. When one attacked another with a knife, the refusal of Aichhorn to interfere so maddened the attacker that he threw his knife on the floor, stamped with rage, and uttered a bellowing which turned into the most violent weeping and finally ended in sleep from exhaustion. Such scenes were repeated with each one of this worst group, the rages

growing less and the behavior better, until they became a homogeneous group in rapport with the teacher. Then gradually more restrictions were imposed, preparing them to bear the hardness of life.

The conclusion to be drawn from this evidence is clear. All who value mental and moral health should work for the day when parents, nurses, and teachers, as part of their regular preparation for their duty, will take a course in ego education and emotional adjustment from one who is trained in one or other of the various technical methods that have been devised for this purpose. Until the state or nation adopts this plan as part of the educational scheme, the task must be shouldered by the pioneers in the mental-hygiene movement.

ATTITUDES AND EDUCATIONAL DISABILITIES

PHYLLIS BLANCHARD, PH.D.

Psychologist, Philadelphia Child Guidance Clinic

IN a recent study of reading disabilities,[1] some of the relationships between that particular type of educational disability and the emotional reactions of the child were described. In the present report, the primary concern is with emotional attitudes as causes of disability in reading or arithmetic, and as barriers to successful remedial teaching. As in the previous paper, our material is too limited to be subjected to statistical treatment. This is probably not much of a handicap, however, as the problem is one that is better adapted to the case-study method of investigation.

There have been several statistical studies, in our clinic and elsewhere, which indicate that the emotional conflicts and the personality and behavior deviations of childhood do not necessarily interfere with educational achievement.[2] Exceptions to this rule occur when the emotional reaction becomes specifically associated with the study of some particular subject or subjects—with the learning situation.[3] At least this seems to be the case so far as one can judge from intensive individual case studies.

The literature on educational disabilities has occasionally referred to this possibility. Dr. Meek, while studying the initial reactions of children to the first tasks in reading, observed that pupils who failed not only lost interest in it, but showed decided dislike to it and refused to put forth

1 *Reading Disabilities in Relation to Maladjustment*, by Phyllis Blanchard. MENTAL HYGIENE, Vol. 12, pp. 772–88, October, 1928.

2 For a review of the literature on this point, see *Educational Achievement of Problem Children*, by Richard H. Paynter, Jr. and Phyllis Blanchard. New York: The Commonwealth Fund, 1929.

3 This statement is not intended to convey the meaning that there are no other exceptions.

further effort.[1] Gates, commenting upon Dr. Meek's report, makes the following statement: "Had such conditions been permitted to continue, the result would doubtless have been, in time, a serious 'disability' in and hatred of reading. Doubtless, many 'disabilities' in reading arise in just this way; perhaps some of them originate in the very first lesson."[2]

Elizabeth Hincks, reporting a series of case studies to show the relation between reading disabilities and personality traits, mentions the probability of emotional factors in etiology in some instances. For example, of one boy she says: "Reading naturally had acquired an association of unpleasantness, since it was done with a father who exploded with anger every time the boy made a mistake." Miss Hincks concludes that many of her subjects "showed lack of interest to the point of positive aversion for reading matter and its content. In some cases it was so strong that the act of attempting to read was really painful." She does not imply that this attitude was the primary cause of the reading disability, however; rather she believes that "the reaction of unpleasantness toward the content of books was probably a conditioned reflex, since the content had always been experienced together with the difficult psychological process of reading it".[3]

While recognizing that disability in reading may be due to any one of a number of possible conditions or combination of conditions,[4] there is evidence in some of our case studies that emotional conditionings may be the predominant factor in etiology. This is also true of disabilities in arithmetic. In the following case reports we shall try to bring out the causal relationship between attitude and disability. The first two are cases of disability in arithmetic, the other three in reading.

1 *A Study of Learning and Retention of Young Children,* by Lois Meek. Contributions to Education, No. 164. New York: Teachers College, 1925.

2 *The Improvement of Reading,* by A. I. Gates. New York: The Macmillan Company, 1927. p. 23.

3 *Disability in Reading and Its Relation to Personality,* by E. M. Hincks. Harvard Monographs in Education, Series I, Vol. II, No. 2. Cambridge: Harvard University Press, 1926.

4 See *Reading Disabilities in Relation to Maladjustment,* already cited.

CASE I

Peter was referred for clinical study and treatment because of poor school work, particularly in arithmetic. He was nine years old and in the high third grade, which he would have to repeat unless his work showed remarkable improvement. It was within two months of the end of the half year when promotions would be determined.

The usual order in clinical study provides that the social history be taken prior to the physical, psychological, and psychiatric examinations. In this case, however, it happened (because of certain practical considerations) that the social worker's first interview with the mother took place while the boy was being given the psychological and educational tests. Because his experiences were unknown at the time of the testing, the report of the psychologist is all the more significant:

"In regard to arithmetic, it is interesting to note that Peter is better at reasoning than at computation. The former is satisfactory for low third, the latter for only high second grade. On the whole, his arithmetic is not so bad, the subject age being 8 years, 5 months, but it is very poor in comparison with his achievement in reading and spelling. *The chief difficulty with arithmetic seems to be the emotional response to it. A distinct blocking is shown in his delayed responses and his reluctance to attempt performances when any test with figures is given.* His errors are erratic, and obviously rise out of a state of mental confusion rather than from intellectual incapacities. He succeeds on difficult examples after failing in easier ones. For instance, after adding 17 plus 2 incorrectly, he adds 16, 53, and 32 rightly; and after giving a wrong answer in subtracting 5 from 16, he subtracts 25 from 96 correctly."

For the rest of the psychological report, it is only necessary to state that the boy's intelligence quotient was 93; that his reading was satisfactory for 9 years, 10 months, and 4.0 grade, and his spelling for 10 years, 10 months, and 4.9 grade.

Peter's mother explained to the social worker that she had always had to worry about him for one reason or an-

other. When he was an infant, it was his health; since then it had been school. Why was she so anxious about the boy? It seemed that her mother had suffered from mental disease and had been in a state hospital for some years; also she had a brother with whom she had given up all contact some time before because of his irresponsible conduct. She had worried about the effect of this heredity on Peter, and had felt that her care and training must protect him from it.

The physical care that she had given the boy showed good results. Although he had been a sickly infant, at the time of his visit to the clinic he was in excellent physical condition. His mother gave a detailed account of the dietary instruction that she had followed during his early years, and that she had evidently carried out very conscientiously.

Her help with his arithmetic had had a different outcome. She began to take this in hand early in his school attendance, but with little success. She tried to "drum it into him", she explained, but he made many mistakes. Even when she threatened, "If you get this wrong again, I'll whip you", he repeated his errors. She whipped him, but this did not seem to persuade him to do better. She was somewhat evasive about the frequency of punishment, but admitted that she had tried it rather often until the principal of the school told her to stop. Since then she has not whipped him "except when he wouldn't say the tables right".

It seems clear that experiences such as Peter had had in association with arithmetical tasks might easily set up a conditioned emotional response to the subject. This is probably just what happened. Undoubtedly, the stimulus "arithmetical task", instead of initiating a chain of intellectual processes leading to the solving of the problem, set up emotional reactions of fear and dislike. These attitudes interfered with the orderly processes of association and memory necessary to do the arithmetical tasks correctly.

With such intense emotional conditioning to overcome, it was obviously impossible to hope for any change before the end of the school term, and Peter was not promoted. Remedial work with the boy was carried on during the three months' summer vacation, the guiding principle being the

necessity of making arithmetic a pleasant rather than an unpleasant experience, and of reconditioning his emotional response to it. To this end, Peter and his tutor nibbled a bit at sweets during the lesson, played games in which arithmetic figured, and occasionally went for an automobile ride, doing the lesson at intervals between discussing the scenery. The tutor noticed that Peter enjoyed the games and could do the arithmetic involved, except when he chanced to think of it as *arithmetic*; if she could keep his interest in the game from flagging so that he did the arithmetic more or less automatically, he got along with it very well.[1]

At the close of the three months' remedial teaching, the arithmetic tests were repeated. The arithmetic computation tests given when he first came to the clinic showed a subject age of 8 years, 2 months, and a 2.8 grade score; the later tests showed a subject age of 9 years, 6 months, and a 3.7 grade score. His accuracy in addition, subtraction, and multiplication had improved remarkably, and he was beginning to understand short division.

Meanwhile, psychiatric treatment had been directed toward work with Peter's mother. As our acquaintance with her progressed, it became very clear that her drive to have him succeed was based on her fear that he, like the members of her family previously described to the social worker, might be mentally abnormal. She was reassured on this point, and was praised for the physical care she had given the boy. The security that she obtained in this way enabled her to accept suggestions for moderating her anxiety about Peter's school accomplishment.

When school opened, an attempt was made to persuade the principal to try Peter in the low third grade. The principal was unwilling to act upon this suggestion, but stated that he would promote the boy if his work during the first

[1] Miss Freda Antinoph, who did the remedial teaching, invented some ingenious methods for unconditioning. She devised games in which pieces of candy were called soldiers, and Peter was to tell how many were left, while he was permitted to eat those that were killed; or another game in which Peter was a cashier in a bank with candy money. Her detailed report of her remedial teaching furnishes interesting material because of the combination of progressive education methods (play motivation) with Watson's suggestions for unconditioning through forming new associations with visceral affects.

few weeks of school confirmed the results of the tests given at clinic. Unfortunately, the second-grade teacher, although not the same one he had had before, was an elderly woman with rigid ideas of discipline. No doubt her stern attitude was sufficient to revive the boy's conditioned emotional responses after the first few days, and his arithmetic was as poor as ever. Hence the hoped-for promotion was not granted.

Peter's mother was by this time sufficiently at ease about his normality to be entirely serene about the grade repetition. But Peter was unable to understand his difficulties. He remarked that he could do arithmetic very well in the summer and he didn't see why he should be having trouble with it now. It is unfortunate that he is too young to grasp the psychological explanation of these puzzling facts.

Despite his bewilderment, Peter does not seem to be unhappy. His mother has ceased entirely to coach him with his home work. Instead of spending the afternoons drilling him in arithmetic, as she used to do, she sends him to the Y.M.C.A. recreational center, where he has a good time with the other boys. Probably his anxiety about repeating the high second grade is a reflection of the attitude his mother formerly had toward grade repetition.

It is interesting to speculate about what might have happened if we could have managed the treatment of this case a little differently. Perhaps it would have been better if Peter could have had a summer free from all thought and mention of arithmetic, since laboratory research has shown that sometimes the conditioned emotional response will weaken or even disppear through disuse. After such a quiescent period, the new pleasant responses could have been set up more permanently, in all likelihood. But this plan could not have been put into effect while Peter's mother still maintained her drive to have him succeed in school, and the remedial teaching with a special tutor at least served as a device to induce her to keep hands off while the psychiatrist gained time to change her attitudes. Next summer, she plans a vacation free from all mention of school work and devoted to recreation.

CASE II

Felix was another boy who had trouble with arithmetic. He was twelve years of age and in the seventh grade. He had transferred from one school to another at the beginning of the sixth grade. In the first school that he attended he had always received very good reports. The second school had somewhat more rigid standards of scholarship, particularly in the upper grades, where the drive for college board requirements made itself felt. From this school Felix received poor reports, especially in arithmetic.

In discussing the matter with the psychologist, his mother said, in part: "It is strange we never thought of him as being stupid before, but he always had such good reports from the other school. His father has tried to help him with his work and has noticed that he does not seem to be able to reason about the arithmetic problems. At first we did not think this was so serious, but now they are suggesting that he be demoted to the sixth grade again. He doesn't seem to have any reasoning ability at all—he just bluffs." She admitted that his father had pointed out his disability to him.

When examined, Felix proved to be far from "stupid", having an intelligence quotient of 122 according to the Stanford-Binet intelligence test. He talked frankly about his difficulty with arithmetic, saying that it was poorly taught at the first school that he attended. "All I ever really understood was the least common denominator." Despite his frankness, he was ill at ease and flushed painfully during the discussion of arithmetic. He remarked that he knew he could not "reason" properly about the problem. "I just look at the figures and try to do something with them."

That this was the method he had adopted was evident in watching him work. His first answers were invariably incorrect because they were guesses. When asked to work the problems aloud, step by step from the beginning, taking time to think them through, he was able to do them correctly.

It was then pointed out to him that he had just shown that he *could* reason correctly and that he could do arithmetic

problems when he took time; that his failures came about because he considered that it was useless to try, and resorted to guessing. After this discussion, the Stanford achievement arithmetic reasoning test was given, and he applied the explanation so well that his achievement was satisfactory for 14 years and 8.0 grade.

The psychologist's interpretation reads as follows: "Apparently, so far as arithmetic is concerned, his attitude toward it has been so conditioned that he has no confidence in his ability to solve problems, feels quite hopeless, and in desperation depends upon guessing. This is what his mother calls 'bluffing', but she thinks it is done deliberately and consciously, whereas it is rather a defense mechanism whereby he tries to release himself from a painful situation which he feels inadequate to meet successfully."

It was considered hopeful that he did not project his difficulties upon the school, but was willing to assume the responsibility for his failures. Because of his frankness in facing his situation, it seemed possible that he could be helped by discussing it further with him. When this was undertaken, he proved to be exceedingly interested. He wished to go over the arithmetic tests in detail. The interpretation of his disability was once more given to him, stressing the point that his discouragement and lack of self-confidence were at the root of his troubles, and emphasizing his good intelligence and the ability to do arithmetic that he had shown on our tests.

Felix was much moved during this interview. He flushed frequently, but kept his voice steady and asked several relevant questions, pressing some topics further than the remarks volunteered by the psychologist. He inquired whether he had sufficient ability to go to college, explaining that he had become discouraged about this since he was getting such poor reports from school, although previously he had planned upon a college education. He was told that with a little help now, in order to overcome his present maladjustment, he should be able to think of high school and college work as within his reach. This led appropriately to the introduction of the subject of remedial teaching, and a plan was broached on the basis of providing him with help until he should be

caught up with his school work, after which he would undoubtedly be able to manage things for himself.

A similar explanation was given to the parents and to the school. Tutoring was provided so that the father's patience need not be tried further in working with the boy. An essential feature of the remedial teaching was building up the boy's confidence in his ability to do arithmetic by keeping a record of his work and showing him the steady improvement that he was making. As his increasing confidence began to carry over into his school work and his marks improved, he was still further reassured as to his capabilities. The demotion that had at one time been considered never took place; on the contrary, he was promoted to the eighth grade at the end of the school year.

CASE III

The case of Richard was partially reported in a previous article,[1] but because the treatment resulted so differently from the optimistic prognosis given at that time, it seems worth while to refer to the initial study very briefly and to give an account of the subsequent remedial work.

Richard, who was nearly twelve years old and repeating the fifth grade, was considered mentally retarded. As readers of the previous article may recall, however, when examined, he had an intelligence quotient of 133 and the real cause of his school failure was a reading disability, his achievement in this subject being more than six years below his mental age and two years below his school grade. (Reading age was 9 years, 2 months, 3.4 grade.) During his first years in school, his father had attempted to help him with his reading, but had been so critical that the lessons usually ended in an outburst of tears from the boy and protestations that he could not do anything his father required. After two years, the father realized that he was making the boy miserable, and discontinued helping him with his work. However, it is probable that by that time a definite attitude of dislike for reading and distrust of his ability to read had been set up in the boy.

[1] See Case IV, pages 785–87 of *Reading Disabilities in Relation to Maladjustment*, already cited.

Psychiatric work was instituted with both parents. With the father the aim was to relieve him of his own feeling of inferiority and sense of failure and to rehabilitate him vocationally. It was hoped that the mother could be given more insight into her reactions toward the father and Richard. It was expected that she would eventually be able to accept the father, and consequently Richard, who was identified with the former in her mind, instead of rejecting them both and turning to her younger son for emotional satisfaction.

From the beginning, it was recognized that only such fundamental changes in the parents would alter their critical feelings toward Richard and permit them to regard him with approval as a normal, lovable youngster. But a long period of time is necessary to help adults to arrive at self-understanding and readjustment. Ten months have not succeeded fully in accomplishing this with Richard's parents. Although some modifications can be seen, it is only the beginning of what we should wish for them.

The persistency of the family tensions has been a very real barrier to remedial teaching for the reading disability. Richard had three months with an expert tutor, but his advance was not so rapid as a boy with his superior intelligence would have made in a more favorable home atmosphere. It sufficed to help him improve his school reports and to win him a promotion, but he is finding sixth-grade work very difficult. Neither the teachers at school nor his mother at home have displayed confidence in his capability, and their distrust, which has been plainly shown, has caused him to retain his attitude of self-depreciation and his dislike of reading. Moreover, on one or two occasions, his mother has been so unwise as to give him an assignment in reading as a punishment for some misdemeanor.[1] What will come of further treatment remains a problem of the future.

CASE IV

Thomas was a nine-year-old boy in the third grade of an excellent private school. His parents requested clinical study on the grounds of backwardness and sensitiveness about read-

1 Aside from the reading disability, which is our primary concern in this study, it should be noted, in connection with the report of the case presented in the previous article, that his behavior has shown little change for the better.

ing. Interestingly enough, he was not very greatly retarded in this subject, according to psychological tests. His mental age was 9 years, 4 months, intelligence quotient 104 by the Stanford-Binet test, while the Gates primary reading tests showed that his achievement in that subject was satisfactory for nine years and 3.3 grade. His sensitiveness was very evident, however; he was reluctant to undertake the tests and insisted that he was unable to read. He was overanxious, asking repeatedly how much more time he had while working on the reading.

There had been much discussion of his reading at home. Apparently his father had been unusually precocious in acquiring proficiency in reading, and was constantly comparing the boy's achievement with what he had been able to do at the same age. Thomas had for some months been refusing to read in his father's presence. He explained to the psychiatrist that if he stumbled or mispronounced a word, his father would immediately "snap him up". He remarked that he did not mind reading to his mother, because she did not scold him when he made a mistake. He added that he did not seem to make so many errors when reading for her.

This case is particularly interesting in that it shows a reading disability in the process of formation. It was caught in time to prevent the development of a real disability, but had the situation described above been permitted to continue over a period of time, undoubtedly the boy's attitude would have become one that would have inhibited normal progress. Very little remedial teaching was necessary, and none has been done outside the school. The treatment was concentrated on leading the parents to realize that the boy's ability was average for his age and grade, and that they had set up too high standards of achievement. The destructive effect of constant criticism and of placing goals too high for the boy ever to attain them was also explained. Since the parents were well adjusted, they were able to understand this intellectual approach to the problem, and consciously to alter their conduct. Thomas was reassured as to his ability by both the psychologist and the psychiatrist.[1]

[1] Had the father's original criticism grown out of personal maladjustments on his part, this simple method of handling the treatment undoubtedly would have been too superficial, and would have failed to produce the desired effect.

A year after the original clinic study, Thomas was again given reading tests. While he still read slowly, his comprehension was satisfactory for fourth grade, which was his school placement at that time. He was much less anxious, the only indication of anxiety being his eagerness to know how he had done on the tests. Both father and mother were satisfied with his progress.[1]

CASE V

This case has recently come to our clinic, so that only the diagnostic study can be reported. It is that of an eleven-year-old girl with an intelligence quotient of 110. Although the major problem is in the behavior field, a minor one is her poor reading.

She hates to read; she will not do assignments for supplementary reading for any of her school subjects, and gets poor marks in those that she must learn from books. Thus her only good marks are for arithmetic and geography (which is taught largely by map-making and project methods). She is now halfway through the sixth grade of school. On silent reading tests, her comprehension is adequate for the beginning of the sixth grade, but rate is only at the 4.5 grade level. The fairly good comprehension is due to her ability to guess at meaning from context in spite of failure to recognize some of the words. In oral reading she makes many errors. Her score on a word-pronunciation test is only 10.8 years and 5.0 grade, while tests demanding sharp visual discrimination for distinguishing one word from another give her only 7.1 years and 1.6 grade proficiency.

Her attitude toward reading (like her misconduct) is a part of her negativistic reaction to her mother and to anything that the mother suggests. She feels much more affection for her father and links herself with him in every possible way. The intensity of her identification with her father is equaled by the force with which she rejects her mother. She

[1] It should be understood that a physical examination is a part of the routine clinical study of cases, and that whenever there is a reading disability, the vision examination is an especially thorough one. For a case of reading disability arising from visual defect see Case III reported on pages 783–85 of the article *Reading Disabilities in Relation to Maladjustment*, to which we have previously referred.

wants to do everything that her father suggests, but rebels against anything advised by the mother. She says, "Seems to me every time I ever told my mother I had nothing to do and wanted her to do something with me, she just told me to go read a book." She insists that she met with this reply before she had begun school.

The mother's unwise stress on reading probably arose from a feeling of inferiority on her own part. The father is a professional man, who has had to read a great deal. The mother is not so well educated and has felt this difference keenly. Since her marriage, the mother has tried to become a reader and has also been anxious to have her daughter interested in books. Unfortunately, she wanted to enforce the habit at an early age, before the child had mastered the mechanics of reading or could obtain any intrinsic pleasure from it. Thus she succeeded only in rousing a resistance in the girl, which has increased in direct proportion to the mother's nagging about the matter.

Perhaps, but for the girl's antagonism to her mother on still other grounds (which are too complex to be given in detail), she would not have developed the dislike of reading, or at least would not hate it so intensely. It is quite likely that while her attitude prevented her from acquiring proficiency in the reading process, this very lack of proficiency now operates to accentuate her attitude. That is, besides the conditioned response set up in association with the mother, the difficulty that she experiences in reading makes it in itself an unpleasant experience. Just where one can make a break in this circular type of response is a nice problem in remedial teaching.[1]

CONCLUSIONS

1. We have presented five cases that show disabilities for reading or arithmetic in which the cause seems to be primarily

[1] While this case is perhaps too mild to be considered a serious reading disability (see definition given in *Reading Disabilities in Relation to Maladjustment,* page 774), the emotional attitude is so marked as to justify its inclusion in this report. At least it is likely that this girl's proficiency in reading is sufficiently poor to interfere with her making the normal educational progress in keeping with her intelligence level.

the child's emotional attitude toward the particular subject. In each case this attitude was the result of parental influence.

2. An important treatment problem seems to have to do with the parents. When their handling of the child can be changed, it is usually possible to change the child's attitude and to overcome the disability by special teaching methods. If the parent-child relationships have grown out of emotional maladjustments on the part of the parents, the treatment process is a long and difficult one, and remedial teaching is apt to prove less effective.

3. The school may also facilitate or retard treatment by providing situations that will give the pupil an opportunity to feel successful, or by keeping him in situations that increase his sense of failure.

4. Undoubtedly, disabilities in other subjects than reading or arithmetic may sometimes arise from emotional conditionings. It happens that our clinic cases are limited to these two subjects. This is probably due to the fact that reading and arithmetic are still to be regarded as the fundamental skills that must be acquired before the pupil can go on to more advanced work in other subjects which depend upon foundation work in these two.

5. It should be repeated that attitude is not the sole cause of educational disabilities. There are many others. It is one that has been too little discussed in the literature, however, and is especially important from the preventive point of view.

6. It seems essential for parents and teachers to understand that criticism and punishment bring into the learning situation an opportunity for setting up conditioned responses that are liable to produce educational disabilities.

DISCHARGES AGAINST ADVICE FROM A PSYCHIATRIC HOSPITAL WITH ONLY VOLUNTARY ADMISSIONS

A STUDY IN SOCIAL PSYCHIATRY *

F. I. WERTHAM, M.D.

Associate in Psychiatry, Henry Phipps Psychiatric Clinic, Johns Hopkins Hospital

IN recent years psychiatrists have ventured more and more into the field of the social application of psychopathology. The increase in our ability to detect mental disorders in their early stages, as well as the more extensive and intensive study of the milder forms of mental disturbances and of the psychopathic constitutions, have brought psychiatry into ever closer relationship with the social sciences. Not infrequently psychiatry—or it is perhaps more just to say psychiatrists—have attempted tasks beyond their capacity in this wider social aspect of scientific psychopathology. Extreme psychiatric proposals in the various branches of education and one-sided solutions of the theoretical and practical problems of criminology and legal practice may be quoted as examples. The more enthusiastic advocates of what often appears to be a sort of diluted applied psychiatry, further and further removed from the base of clinical psychiatry as a branch of modern medicine, might well remember that a very large part of the community still views this encroachment with grave suspicion.

Has psychiatry studied adequately those social problems which are most closely related to the care and treatment of mental patients? This question is asked by not a few observers of social phenomena, as, for example, recently by Londres in his attack on psychiatric procedure, especially the circumstances connected with the confinement and discharge of mental patients.

* Read in abstract at the meeting in celebration of the fifteenth anniversary of the Henry Phipps Psychiatric Clinic, Johns Hopkins Hospital, April 30, 1928.

It is proposed in the present study to investigate a situation frequently encountered by the practicing psychiatrist—namely, discharge against medical advice. Here evidently in most cases psychiatry does not deal with the individual patient alone, but faces definite social responsibilities. The question of premature discharge is a very old one, but the situation has changed a great deal with the development of the procedure with regard to mentally afflicted persons. Originally mental patients were detained in prisons and there was no difference between the "insane" and criminals, as the old historical records show. They were later segregated from criminals in special places which were nothing more than prisons, although used only for the "insane" (*e.g.,* the old *Narrenhäuslein,* as they were called, in Germany). This development seems to have begun in several countries in the fifteenth century. From this original germ, so to speak, the later places of detention and treatment — asylums, institutions, state hospitals, psychiatric clinics—have evolved. The *casa di custodia* of Italian criminologists, a "hybrid institution" for both penal detention and psychiatric-therapeutic procedure, represents an interesting stage in this evolution. In the famous Bastille in Paris there were confined, as Sérieux and Libert [1] have found from a study of the old archives of the prison, a "notable proportion" of mentally ill individuals, against whom there were no criminal charges. They were sent there as a matter of social policy, far in advance of the times. In popular opinion there is still a certain connotation of the "prison" connected with the concept of mental hospitals, partly unjustly, but not entirely so. The fact that a legal procedure is frequently necessary in order to have a patient admitted to a mental hospital of course plays a part in the readiness with which the popular mind makes the archaic analogy between the psychiatric hospital and the prison.

Systematic studies of discharges against advice from hospitals with only voluntary admissions have not been made.

1 *Prison d'Etat et asiles de sureté. Les anormaux constitutionnels à la Bastille; interprétateurs, revendicateurs, fabulateurs,* by Paul Sérieux et Lucien Libert. *L'Encephale,* Vol. 6, p. 192, 1911.

Discharge from such hospitals is of course very similar to discharge from other mental hospitals,[1] but it presents new aspects of the problem and shows in a more precise form the general problem of the relation of the psychiatric hospital to the community. If, year after year, patients are given the benefit of psychiatric treatment in a hospital especially adapted to their needs, and if some of them after admission leave the hospital before their discharge seems medically advisable, a number of questions present themselves for investigation. The physician is apt to describe this state of affairs *a priori* as due simply to ignorance and prejudice. For a more socially oriented psychopathology, however, a number of unsolved problems arise. How many and what type of psychiatric patients will leave the hospital? Does the initiative for the change come from the patient or from his relatives and friends? What are the reasons for the change? What aspects of hospital life enter into the decision of the patient's leaving, and can they perhaps be modified? How great is the danger to the community from these discharges? How do they contribute to the question of the medical indication for hospital treatment for the various types of mental patients? What is the distribution, both actual and psychological, of responsibility between the individual, the family, and the community?

The material of the present study includes all the patients discharged against medical advice from the Henry Phipps Psychiatric Clinic, Johns Hopkins Hospital, during a period of eight years. It is a matter of routine in the clinic to have persons who ask for what is considered premature or undesirable discharges sign a statement which explicitly states that they assume all responsibility. In this procedure the intention of the physician often is to make relatives or friends

[1] A valuable study of discharges against medical advice has recently come from St. Elizabeths Hospital, Washington, D. C. (see *Careers of Patients Discharged Against Medical Advice From St. Elizabeths Hospital 1920–1925*, by Elmer Klein, M.D., and Roger S. Cohen, M.D. MENTAL HYGIENE, Vol. 11, pp. 357–68, April, 1927). The cases of this study were formally committed either by law or by executive order, and the discharge against advice occurred mainly in a setting of legal reversal of commitment. It is noteworthy that even in this group of committed cases 25 per cent of the patients concerning whom information was gained were able to remain outside of mental hospitals.

more thoughtful. During the eight-year period included in this study—from January 1, 1918, to the last of January, 1926—193 patients were discharged against medical advice. The number of patients treated during the same time and discharged according to medical routine was 2,758. This means that of the patients discharged during the eight-year period, 6.54 per cent were discharged against medical advice. It would have been difficult to estimate this percentage without exact calculation. It is significant on several scores. The evaluation of this percentage as either high or low depends on the point of view from which it is regarded. One must take into account the fact that the clinic admits all types of patients, from those with slight disease manifestations to those with very severe ones. The general public, including official social and legal authorities, as well as average medical opinion, would assume that a very large number of mental patients have to be kept against their will. From this point of view the number of those discharged against advice seems low. In view of the widespread and persistent popular ignorance concerning mental patients, it might be added that the belief that the more severely disturbed patients are so sick that they do not know what they do or where they are is erroneous. On the other hand, one must remember that the Phipps Psychiatric Clinic can choose its admissions carefully and calculate the eventualities of the patient's and the family's attitude. From this aspect the number discharged against advice seems rather large.

Of these 193 patients 99 were men and 94 were women. The average age of the men was thirty-seven (ranging from nine to seventy-one); the average age of the women was thirty-four (ranging from thirteen to sixty-two). The average age of the whole group was thirty-six. These averages show no significant difference from those of the general run of patients. The same statement holds true for occupations.

The average duration of the stay in the clinic of these patients was 54 days. The shortest stay was one day; the longest stay, 295 days. These figures present nothing unusual

as compared with the average duration of stay of other patients.

The distribution of psychiatric diagnoses among the 193 cases was as follows:

Depression	73
Manic excitement	4
Schizophrenic reaction type	38
Psychoneurosis	19
Organic reaction type (other than general paresis)	11
General paresis	17
Affective reaction with schizophrenic features	7
Constitutional psychopathic personality	6
Delirium	6
Drug addiction	2
Chronic alcoholism	2
Paranoid psychosis	2
Chorea	2
Epilepsy	3
Toxic goiter	1
Total	193

The predominance of depressions is interesting, but is in large part explained by the greater number of depressions among the cases admitted. This is due to the tendency on the part of the clinic to prefer therapeutically hopeful cases. This selection, however, does not entirely explain why there are so many depressions. It is evidently not easy for the social environment of a patient to recognize the milder manifestations of depression as morbid and belonging to the sphere of psychopathology. When the number of depressions (73) is contrasted with the number of manic excitements (4) this is particularly clear. In elated conditions the environment takes a very serious view of the patient's condition, although prognostically these conditions are not less benign than depressions.

The relatively large number (17) of general-paresis cases is also noteworthy. In this condition, on account of its characteristic symptomatology and course, the patient frequently has very little insight and it often is a very long time before the environment realizes that there is a profound mental disturbance present.

The small number of cases of drug addiction (2) and of

chronic alcoholism (2) is due to the fact that these patients are admitted to the clinic only in exceptional cases.

The small number of paranoid psychoses (2) discharged against advice (compared with the much larger number of paranoid psychoses treated during the same period) shows that these conditions can be treated in psychiatric hospitals without commitment much more extensively than is commonly assumed.

The difficulty of disentangling the psychological causes of social events is apparent when it comes to assigning the initiative for the disregard of medical advice for further treatment. It would seem at first glance that it should be possible to distinguish neatly between the group in which this initiative came from the patient and the group in which it came from his family. A closer study of the data, however, makes it necessary to formulate a more relative classification.

There is one group of cases in which *the patient demands to leave.* It may be pointed out here that since the clinic admits only voluntary patients, the patient has to be discharged in the event of his definitely wishing to leave. In such cases the family is informed and advised to take the patient to another hospital. Cases in which the family complied with this request and the patient was transferred immediately to another psychiatric institution are not included in the present study. The group of patients in which the initiative for the discharge against advice came from the patient includes those cases in which the patient demanded release, disregarding the advice either to stay or to go to another psychiatric institution, and was taken home by relatives.

A second group of discharges against advice comprises those cases in which *the family wishes the patient to leave.* In this group are included only those cases in which it is entirely clear that the initiative came directly from the relative and not from the patient. In this second group a smaller subgroup was singled out in which it could be clearly shown that the relatives took the patient home, not only without his wanting to go, but expressly against his wishes.

A third group of cases was found more difficult to define,

the *initiative* for leaving the clinic being *divided between the patient and his relatives*, the patient persuading his undecided family to take him away.

In a fourth group the discharges against advice occurred in the following setting: The *clinic wished the patient to leave,* for various reasons to be discussed later, and the family was *advised* to *transfer* the patient to another psychiatric institution. Instead, they disregarded the advice and took the patient home.

In a small fifth group the patient was discharged on trial for an *experimental visit* home, to return to the clinic after a certain time, but instead of returning he *remained away.*

The distribution of cases among these five groups is as follows:

	Cases
Group 1. Initiative due to patient	26
Group 2. Initiative due to family of patient	99*
Group 3. Family is persuaded by patient to take him out	47
Group 4. Clinic advises transfer, but patient is taken home	17
Group 5. Trial discharges	4

* In 10 of these cases the patient was removed expressly against his own wishes.

These figures show definitely that the largest number of patients are taken out by their families. In only 26 cases out of 193 was the patient's demand to leave the decisive factor.

The third group differs from the first in that although the patient has expressed a wish to leave, he could have been induced to remain, had not an active part been taken by the family. In these cases the members of the family either identified themselves with the wishes and reasons of the patient or they magnified, exaggerated, or distorted them. Since in these cases it is the family that takes the active part and comes into disagreement with the physician on the question of the discharge of the patient, one may in a sense say that in 146 cases out of a total of 193, the family attitude presented the physician's problem, as against 26 cases in which the attitude of the patient led to the change (leaving out groups 4 and 5 where hospital arrangements entered into the situation).

The next step of the inquiry was to determine the motives

behind the discharges against advice. One-half (13) of the patients in the first group, in which the patient demanded his discharge, gave no reason for their wish to leave. In the other half of this group the reasons given were the following: resentment on account of confinement; dissatisfaction with the ward; the patient's opinion that treatment in the clinic was unnecessary; lack of confidence; discontent with the hospital; discomfort from drug-withdrawal cure; and, in one case of exophthalmic goiter, fear of operation. The diagnoses of the patients in this group were as follows: drug addiction; brain tumor; spasmodic tics; agitated depression (2 cases); agitated depression with paranoid features; hypochondriacal depression; anxiety neurosis with depression; schizophrenic reaction type with depressive onset; hypomanic reaction type in a chronic alcoholic; exophthalmic goiter; cerebro-spinal syphilis; chronic alcoholism; and tabes. There is little of interest in the details of discharge of these patients.

In the second group, which includes patients taken from the hospital at the wish of the family, the actuating motives are more interesting and significant, since they throw light on the social relationship between the psychiatric hospital and the public. Again, as in the first group, no reason was given in approximately one-half of the cases (52 out of 99). In the other half of the cases the family, in asking for the patient's discharge, gave a motley array of reasons, some of which had little, if anything, to do with the clinic or the patient's sickness and treatment except in so far as it caused a separation of the patient from his family. For example, a husband wanted his wife to be at home, or a wife her husband; a mother wanted her children at home; the relatives had promised the patient to remove him after a certain time; a wife wanted her husband at home because she was jealous of his special nurse; the responsible member of the family was himself mentally disturbed (2 cases).

Other reasons were based on the attitude of the relatives toward the patient's illness. For example, they had no insight into the patient's condition; they made their own diagnosis or wished to map out their own treatment; they misunderstood the patient's behavior (depression, delirium);

they found his improvement too slow; they thought the best thing for the patient was a "change"; they wanted to try a cure in the country; they wanted treatment at home; they considered the case "incurable", "hopeless", "might as well die home". The diagnoses of the cases in the last mentioned group were organic brain disease; depression with schizophrenic features; post-traumatic aphasia; reactive depression.

Further reasons were concerned with the attitude of the relatives toward the clinic itself: they objected to a psychopathic hospital; they believed that the hospital "made the patient ill" or kept him ill; they did not coöperate with the clinic; they were dissatisfied with the visiting routine; they were dissatisfied with the special ward where the patient was; they were dissatisfied with the treatment; they objected to the discharge of an inefficient special nurse. In 2 cases (out of 193) the question of expenses was a main issue. It should, however, be pointed out that the Phipps Clinic is in the fortunate position of being able in certain cases to adjust expenses to the financial status of the family.

In the third group of cases, classified as those in which the family is persuaded by the patient to take him home, no reasons were determined in 16 discharges out of a total of 47. For the remaining 31, the following reasons were given: desire to be home, "homesickness" (14 cases); discomfort due to drug-withdrawal cure; patient's lack of insight into his condition; general lack of coöperation in regard to his treatment on the part of the patient; patient's delusional ideas; "cruelty in hospital" (1 case); dissatisfaction with ward; discontentment on account of hospital confinement; patient's belief that the hospital "kept him ill" (3 cases).

There are, then, two final groups (21 cases) in which the clinic either advised the relatives to take the patient to another psychiatric institution and they refused and took him home instead (17 cases), or in which the clinic advised and arranged a trial discharge or experimental visit of fixed duration and the patient remained away (4 cases).

It is not without interest to determine which member of the family took the initiative and responsibility in removing

the patient against medical advice. In only 25 cases did the patient leave by himself.[1] Seventy-four patients were taken out by husband or wife. Parents took out their children in 34 cases; in only 10 cases did children take out their parents. Patients were removed from the clinic by brothers or sisters in 17 cases. In 33 cases several members of the family took joint action. Too definite conclusions should not be drawn from this distribution. It is of importance, however, that in only 25 cases (12.9 per cent) did the physicians have to deal with the patient alone. In all the other cases the family was the socially decisive factor. The ratio of 34 parents who took out their children to 10 children who removed their parents may point to an overconcern of parental affection and perhaps to a certain lack of concern of the children for their parents.

Of special importance to the physician should be those cases in which the family is divided against itself. This situation is sometimes not brought out or sufficiently considered during the patient's stay, but becomes apparent only when he has to be discharged against medical advice. In this material, disagreement in the form of husband vs. wife's relatives and wife vs. husband's relatives is the most frequent. Very typical of this is the case of a young woman twenty-seven years old who was suffering from a recurrent depression with self-reproaches and suicidal ideas. When the husband came to remove his wife from the clinic and to take her home against medical advice, he answered my questioning as follows: "It is against my better judgment. Her family wants it. They insist she will not get well here because she is worried at having to stay here." Speaking about the seriousness of the suicidal risk, he said: "They just don't believe it. They are not capable of judging. I have put up with an awful lot these eight months from her family—more than you can imagine, Doctor." In such cases the physician finds himself face to face with two factions of the family and has a definitely social task that is not easy, but that nevertheless should not be shunned.

1 A distinction has been made between the group in which the initiative for leaving was due to the patient (26 cases) and the group of patients who left on their own responsibility and by themselves (25 cases).

The opinion of the clinic as to the progress of the patient during his stay in the clinic is shown by the following figures:

	Cases
Improved	83
Slightly improved	5
Unimproved	104
Not treated	1

This shows a marked predominance of the unimproved cases. It would be difficult to compare these figures with the corresponding figures for routine discharges. The fact that the majority of the patients discharged against medical advice were unimproved at the time of discharge speaks for itself.

The further career of all these patients was investigated through an interview of the patient or his relatives by a physician wherever possible; otherwise by letter or through "follow-up work" by a social worker.[1] It is a fact well known, though insufficiently taken into account in statistical psychiatric investigations, that it is exceedingly difficult to determine in any large number of cases to what extent an adjustment at home is really due to improvement or recovery of the patient and to what extent to a stretching of all possible resources and makeshifts of the immediate environment to which the patient returns. In the individual cases this elasticity of the home and work environment is of the greatest importance for the determination of the need of hospitalization and its duration. The heading "satisfactory adjustment outside of the hospital" is, therefore, to be taken as an unavoidably relative statement of the facts.

The subsequent careers of the 193 patients discharged from the clinic against medical advice may be tabulated as follows:

	Cases
1. No information	21
2. Returned to mental hospital	60
3. Admitted to jail	1
4. Unimproved at home	15
5. Suicides	8
6. Suicidal attempts (with subsequent adjustment, 3 cases; with subsequent admission to mental hospital, 5 cases)	8

[1] I am greatly indebted to Miss K. K. Barton, head of the psychiatric social-service department of the Johns Hopkins Hospital, for her aid in this follow-up work.

	Cases
7. Sudden death, possible suicide	1
8. Homicidal attempts (with subsequent admission to mental hospital)	8
9. Died	7
10. Satisfactory adjustment outside hospital	64

If one subtracts from the total number the cases in which no catamnestic information could be obtained and the patients who have died, it appears that out of 165 cases, 64 made a satisfactory adjustment outside the hospital. This seems a comparatively large number. A slightly larger number of patients (73) had to be readmitted to psychiatric hospitals.

Homicidal attempts occurred eight times, if one includes two serious homicidal threats. The diagnoses of the patients who made homicidal attempts were: recurrent depression; agitated recurrent depression with a possible early organic basis; paranoid reaction type; anxiety neurosis with paranoid trend (jealousy delusions); constitutional psychopathic personality; alcoholic hallucinosis with schizophrenic features; schizophrenic reaction type with some hysterical features.

The "homicidal attempts" include the following: threats to shoot wife; threats to shoot children; attempt to choke wife; pursuit of family with carving knife (followed by arrest by police); pursuit of wife with large butcher knife; firing of three shots into wife's neck, two days after discharge; attack on father with a carving knife, with resultant slash from his forehead to his throat.

Considering the large proportion of depressions in the whole group under consideration, the number of suicides (8) is relatively small. The suicide rate of patients discharged according to medical routine in the same period, which is of course a very much larger number of patients, is higher. It would seem from the figures that the danger of suicides and serious injury to others is somewhat smaller than one would assume. The real difficulty is a selective one—the determination of the suicidal risk in the individual case. Just as the psychopathology of suicide is not as yet clear, so our prognostic aids with regard to suicide are still very incomplete. It would be unwarranted clinical pessimism to claim that the determination of the degree of danger of future suicide will always be a matter of the individual case beyond

any more far-reaching generalizations. There must be here, as in other psychopathological phenomena, typical chains of events which a deeper analysis will reveal. It is possible that among the 8 patients who died there were cases in which death might have been preventable had they remained in the hospital.

It has not been the aim of this study to exploit all the statistical possibilities of the material and to force the data into a frame of diagnostic labels, average course of disease, and so forth. Rather did it seem worth while to study a situation that falls within the scope of social pathology for itself, with a view to deriving practical conclusions in regard to possible elaborations and modifications of psychiatric procedure. Out of an average number of 366 admissions per year, 24 cases (6.55 per cent) are discharged against medical advice. Depressive conditions and organic reaction types, especially general paresis, deserve to be mentioned as entering to a considerable extent into this number. Manic excitements are conspicuous by their rarity, as are also—contrary to expectation—essentially paranoid psychoses. As regards sex, social status, profession, and length of stay, the cases studied do not show significant variations from the average of admitted patients.

Subtracting the cases in which considerations of the clinic entered into the discharge, it becomes evident that in only 26 cases, or 15.1 per cent, was the discharge due to the patient's wish alone. In the majority of cases (99, or 57.5 per cent), the family took the initiative, while in 47 cases (21.5 per cent) there was a combination of factors, with the family, however, as the decisive agent with whom the physician had to reckon. Some of the reasons given by the patients seem to refer to causes of discontent unavoidable in any large number of hospital admissions. The reasons given by the family have partly to do with the general social consequences of mental diseases. Since they are usually of long duration, the separation of members of the family is a motive for interrupting the treatment. In many cases some member of the family demands the discharge of the patient for the selfish motive, often disguised as unselfish

interest, of having the patient at home. This motivation is very common and familiar. It is mentioned by Rieger among the reasons for discharge of psychiatric patients in Würzburg at the beginning of the seventeenth century.[1] In a large number of cases there is a misunderstanding of the workings of the clinic. Often the decision of relatives to try something else—either a definite procedure, such as "gland treatment", or just a "change"—becomes understandable when one considers that in many cases of mental disease there may be prolonged periods in which treatment has to consist of protection of the patient rather than any active therapy.

Many of the reasons given by the family are accounted for by the general deep-rooted prejudices of the average public in regard to mental diseases. From these general prejudices it is well to distinguish the more specific misapprehensions, doubts, and false inferences caused by the direct contact of the family with the workings of the psychopathic hospital. The current false beliefs concerning mental disease call for a general education of the public; this is an old demand. It is satisfied to some extent, though not completely, by the efforts of the present mental-hygiene movement. The more specific difficulties arising from the direct contact of the family with the psychopathic hospital, however, are not covered by a program of general education.[2] The material of this study would seem to show that there are definite difficulties from which can be derived certain hints as to methods of obviating them.

[1] He gives as an example the record of a patient in the year 1609: "*Junevis 25 annorum, prorsus furiosus . . . a patre domum reducitur eo, quod mater fillii absentiam ferre non possit.*" (A young man of 25 in a state of severe madness . . . was taken home by his father, because the mother could not bear the absence of her son.) *Die Psychiatrie in Würzburg von 1583–1893,* by Konrad Rieger, 1899. p. 140.

[2] An interesting and successful arrangement has been inaugurated by Dr. Ebaugh at the Colorado Psychopathic Hospital. The relatives of each patient are invited to attend a series of lectures given by different members of the staff in which the theoretical and practical aspects of mental disease are developed. (See *The Rôle of Conferences With Relatives in the Educational Program of a State Psychopathic Hospital,* by Franklin G. Ebaugh, M.D. MENTAL HYGIENE, Vol. 9, pp. 753–59, October, 1925.) A personal communication from Dr. Ebaugh indicates that discharges against medical advice have occurred less frequently at that hospital since the institution of this procedure.

It appears necessary to emphasize what is shown clearly by the data studied here, that in its social aspect mental disease is not only a problem between the individual and the community in general. In our present-day social and legal organization, so far as the practical social problems of mental disease are concerned, the family as a decisive entity is interpolated between the individual and the community. It is not my intention here to discuss in more detail the legal and moral background of this responsibility of the family. From the administrative point of view, the family's importance is clear enough. A number of patients considered in this study could have been committed and should have been committed; but this was made impossible by the refusal of the family. It is sufficient to state that the social aspect of psychopathology is not, as is too often assumed, exhausted by a consideration of the more or less abstract or absolute needs and safeguards of the community. Every reason given by the family for interrupting a course of treatment deserves careful investigation. This cannot be done abstractly and in general, but should be taken up in each individual case. The circumstances of discharge against advice is only an occasion for the showing-up of a misunderstanding or a disharmony that must have existed long before. This issue is one in which Dr. Adolf Meyer's suggestion of a special formulation of every psychiatric case for the patient, for the physician, *and* for the relatives assumes particular importance. It would seem necessary for the physician to express his findings of a specific mental disease in a way that the family can understand. He will have to explain in simple terms the varieties of treatment and more especially the indications for hospital treatment. The latter point, particularly, presents great difficulties because psychiatric literature seems to have shunned the task of attempting a more precise formulation of the indications for hospital treatment. The more the modern development of psychiatric hospitals with voluntary admission wards gains in extent, the less will it be possible for the physician to rely on legal authority.

The success of coöperation with the family will depend on the clearness and honesty with which the individual case

can be presented to them. That a simple diagnostic label or a formal "mental age" is not sufficient to supply this need is evident. Nor is it sufficient to give the relatives a short-story-like résumé of the more dramatic features of the development of the patient's abnormal behavior. Nor are statements as to the patient's actual behavior sufficient, however well formulated. Without discussing whether or not this is unavoidable, it is a fact that psychiatric terminology, even where it is not Greek or Latin, has developed into a kind of jargon in which words have assumed meanings that they do not have in general usage. To take an example from Londres,[1] who is a reporter and a very good one, reflecting well the attitude of the public, a patient has been in a psychiatric hospital for several years, and as in the case of a considerable number of patients in this study, there is a division within the family. The cousins visit the patient and, finding him "so clear", suspect the right of the wife to keep him in the hospital. They ask an explanation from the physician and receive the following statement: "Mr. X. is physically in very good condition. From the mental point of view, he is calm and docile, but he is unconcerned, indifferent, unoccupied, little conscious of his real interest and without care for his future. His place is still in the asylum, for he could not adapt himself any more to social life." Psychiatrically, this is a clear enough statement of a typical condition. Londres' comment is bitter and partly unjust, but it reflects so well the attitude of relatives, as manifested in the cases of this study, that it may be permissible to quote it here: " 'He's unconcerned!' Why then did he cry for his cousins who finally took him out?

" 'He's unoccupied!' He could perhaps, in recompense for the good care with which he is surrounded, construct a monument in honor of the physicians of the asylum?

" 'He's little conscious of his real interest!' Do you see this person who has been confined for six years and who permits himself to be without concern for the future?

" 'His place is in the asylum because he could not adapt himself any more to social life!' Surely this chief physician

1 *Chez les fous*, by Albert Londres. Paris, 1925.

does not know what he writes. With these conditions I could have confined twenty of my best friends in one morning—and also the said chief physician."

No one with practical experience of psychiatric procedure will fail to realize that this chief physician's statement is a typical one and not even a bad one; but equally typical is the reaction of the public, in this instance the reporter. The statement of the chief physician steers clear of diagnostic labels and formal prognoses. It is based on facts and accurate data of observation. But how abstractly it is expressed! How vague is the general phrase, "adaptation to social life"! It describes a phantom in an equally impersonal world, the "asylum".

A great deal of the uncertainty of families in their contacts with mental hospitals is explained also by the differences in the expressed opinions of different hospitals to which the patient is successively admitted. Cases 4 and 5 of the present study (see page 582) are examples of how great these discrepancies of formal clinical diagnosis can become. Bowman[1] has recently drawn attention to the "enormous duplication of effort by psychiatric clinics", when patients are brought from one hospital to another after having been thoroughly studied. "Only after a complete social-service investigation is it found out that the patient has been to another clinic."

The divisions within the family brought out in a number of cases in this material deserve to be singled out as a phenomenon that has to be taken into account practically and during the patient's stay in the clinic.

From the further fate of the patients discharged against advice the conclusion can be drawn that on the whole the danger of discharge against advice is apt to be overestimated. As a result of this study it seems justifiable to make the statement that when the relations of the physician with the family come to be regarded as forming an essential part of practical psychopathology, extension of the organization of

[1] *Medical and Social Study of 100 Cases Referred by the Courts to the Boston Psychopathic Hospital*, by Karl M. Bowman, M.D. MENTAL HYGIENE, Vol. 12, pp. 55–71, January, 1928.

psychiatric hospitals with wards for only voluntary admissions is practicable and desirable.

The more clinical aspects of the catamnestic data do not fall within the scope of this study. Investigations of the careers of these patients throw some side lights on certain social aspects of mental diseases. The insignificant rôle at present played by family physicians in the case of mental patients is apparent from this material. (For example, see Case 3, page 582.) There is a great tendency on the part of the physician to give up the case entirely when a serious mental illness develops. Some of the more out-of-the-way treatments taken by patients after discharge are interesting. The cases in which a spell cast on the patient was regarded as the cause of the disease and in which aid was sought by exorcistic means deserve mention. (Examples: Cases 21, 29, and 30, pages 585, 587.) The danger of maltreatment of patients by their families, when home treatment is substituted for hospital treatment in cases in which the latter is definitely indicated, needs to be emphasized. (Example: Case 26, page 586.) The cases where the home environment was apparently instrumental in bringing about an improvement may be pointed out. (Example: Case 7, page 583.) A fuller discussion of these cases would lead more deeply into the psychopathological and clinical aspects of the material than is intended here.

In conclusion, another practical application of the deductions from this study may be alluded to, although it lies somewhat outside the field of clinical psychiatry. Criminologists and psychiatrists have in recent years advocated the introduction or rather the extension of the legal practice of "indeterminate sentence". It has been claimed that the decision for the duration of the legal sentence should be turned over to psychiatric opinion. It would seem that before psychiatry can pronounce upon such questions of social prognosis in any more than a purely empirical fashion, the social aspects of the narrower field of psychopathology will deserve further careful scientific study, in the direction indicated in this paper.

The following illustrative cases are cited as examples in brief summaries, only the essential facts relative to this study being given:

Case 1.—Housewife; aged thirty-nine; married. Husband a clerk. Psychoneurosis. Improved. She was taken out by her *husband* who was *"more difficult to handle than the patient"*. He begged to be allowed to see the patient more frequently than regular visiting days, *complaining of "lonesomeness"*, the difficulty of "bearing the first separation since marriage, inability to sleep or attend to business", and so forth. During one of his too frequent visits, he found the patient slightly discouraged and in a mood to enlarge on her complaints. He became "very much worried", "could not sleep all the following night", and without consulting the patient or the physicians, made arrangements to take the patient home. A report five years later said that the patient had improved since leaving.

Case 2.—Housewife; aged twenty-five; married. Husband a butcher. Agitated depression. Unimproved. Papers were made out to commit the patient to a state hospital, and her husband intended to take the patient there. On the day of the discharge, another relative came to the hospital with the husband and persuaded him to take the patient home instead of to the state hospital. The seriousness of this was explained to them. *The day after leaving the clinic the patient took a large quantity of iodine and died* shortly after.

Case 3.—Housewife; aged forty-one; married. Husband a "canner". Recurrent depression. Unimproved. The patient was taken out because her sisters became angry because they could not all visit her on visiting days. The sisters' physician (consulted by the family) and the sisters felt that the clinic had a personal interest in keeping the patient, that its attitude was due to jealousy and the fact that it was peeved. *Five years later the patient was reported as living with her sisters—never recovered—spending most of her time in bed, with diminished affect and reduction of all activities.*

Case 4.—Housewife; aged forty-seven; married. Husband a carpenter. *Hypochondriacal depression.* Improved. The patient became very persistent in her demands to leave, and her husband took her home against advice. She was later admitted to private sanitariums and hospitals with the following diagnoses: *"nervousness"*, *"involutional melancholia"*, *"neurasthenia"*. The patient is still in a state hospital; diagnosis: *agitated depression.*

Case 5.—Schoolboy; aged fourteen. Father an upholsterer. Schizophrenic reaction type. Unimproved. The patient was discharged to his mother for admission to a state hospital, but she took him home instead. A month later he was taken to a state hospital where he spent a year. *Diagnosis: dementia praecox.* Two years later he was admitted to another state hospital, where he spent about two months. *Diagnosis: manic-depressive insanity, depressed phase.* One day, after leaving this hospital, the patient was again admitted to the first state hospital, where he was diagnosed as a *constitutional psychopathic inferior without psychosis.* He died in this hospital of tuberculosis of the lungs five months after his second admission. (This case and the preceding one illustrate the pitfalls of formal diagnoses.)

Case 6.—Housewife; aged thirty-eight; married. Husband a mechanic. Recurrent depression. Unimproved. *The patient was removed from the clinic because her husband objected to having her on the disturbed ward, although the patient herself made no complaints.* A report eight years later stated that she was at home for two weeks after leaving the clinic, and then spent several months at a private sanitarium. She left there to return home, where she remained unchanged for four years. Since then she has been perfectly well. The patient attributes her illness to grief and her recovery to prayer. She thinks she might have been well at an earlier date if she had remained in the clinic longer.

Case 7.—Housewife; aged thirty-five; married. Auditory hallucinosis (schizophrenic—possibly toxic basis?). Improved. The patient was taken home by her husband and sister because she said that she would be more satisfied at home. A report seven years later stated that *the hallucinosis ended abruptly on departure from the clinic. The patient was precipitated into a situation demanding great activity.* She has been well since.

Case 8.—Tailor's helper; aged twenty-six; married. Dementia paralytica (depression). Improved. *The only reason for taking the patient away was that his wife wanted him at home.* He was later admitted to several hospitals in succession. In one of them he was diagnosed as psychoneurosis—neurasthenic type.

Case 9.—Housewife; aged thirty-five; married. Husband a traveling salesman. Chronic invalidism. Improved. The patient's husband took her home because she was *"homesick"*. A report four years later says: *"After return home* the patient was in practically the same condition as when she entered the hospital. It seemed impossible for her to get her mental processes on the right track. Finally she was *induced to become a Christian Scientist* and succeeded after some months in turning her thought away from herself through this route. She *now leads a much more normal life."*

Case 10.—Machine worker; aged forty-five; married. *Recurrent depression.* Improved. The patient was *taken home* by his wife—*no reason* given. He was soon admitted to a private sanitarium, where he was diagnosed melancholia. After a month's stay he was discharged home, to be readmitted later. He died after two years. The patient's wife stated that she had tried to keep him at home for a while, but he got so bad that he had to be taken to the private sanitarium. *On one occasion he tried to choke her.* After his death the patient's wife was *told that he died of paresis.*

Case 11.—Housewife; aged thirty-nine; married. Husband a driver. Reactive depression. Improved. The patient's *husband insisted upon taking the patient home "because there was no one to look after the baby"*. "The baby cries all night and keeps us all awake." Arrangements were made to board the baby in a nursing home, but the husband would not consent to this. The patient felt that something unpleasant was going to happen and did not want to leave the clinic, but was forced to do so by her husband. A report six years later stated that the patient

has been *all right since leaving* the clinic. Her brother wonders "how she keeps from going crazy" with all that she had to stand from her husband and son (both alcoholic and abusive).

Case 12.—Woman; no occupation; aged thirty-eight; single. Depressive stupor with schizophrenic features. Unimproved. The patient's *family decided to take her home and have to stay with her the nurse who was discharged from the case for tying the patient in a continuous tub and leaving her, allowing the temperature of the water to get too high.* Five years later her aunt reports that the patient has been working.

Case 13.—Bookkeeper; aged thirty-five; married. Schizophrenic reaction type. Unimproved. The patient wrote a letter home pleading to be taken away from the clinic. He was suspicious of nurses and doctors. His *father claimed that nicotine,* which he had absorbed through his *excessive smoking, was producing the patient's symptoms.* The patient accepted this as the etiology of his illness. Six years later the father writes: "He is very much better than when in the clinic . . . would say that he is not more than a quarter as bad as he was at that time. He still feels somewhat depressed at times and that people do not care for him, but is cheerful most of the time."

Case 14.—Sheet-metal worker; aged fifteen; single. Manic-depressive reaction type. Unimproved. The patient was resistive, and his *father decided that all he needed was discipline and took him home.* The father could not be convinced that the patient had any mental disorder. The patient was later admitted to a municipal psychiatric hospital and to a private sanitarium. The diagnosis was constitutional psychopathic inferiority.

Case 15.—Schoolgirl; aged eighteen; single. Father a business man. Schizophrenic reaction type with affective features. Unimproved. Her *mother insisted upon taking the patient home, saying that the hospital had made the patient much worse* and that she could make her well. Three years later the father reports that the patient had apparently recovered. "The service of psychiatrics is in its infancy in my opinion, and, frankly, unless changes have been made in the methods practiced when my daughter was there with you, I think studies along the line of deeper soul thought would show better results with most patients."

Case 16.—Single girl; aged seventeen; no occupation. Father a clerk. Constitutional psychopathic inferiority. Unimproved. The patient's *mother* came in a distracted state. She *had promised the patient to take her home and did not want to break her word.* Five years later this mother reported: "I think I made one of the worst mistakes of my life in ever putting my dear daughter in any sanitarium. I sent her to Hopkins for observation and to be X-rayed to see if they could locate her trouble; of course the child was nervous and toxic all the time. But all that came from her kidneys . . . she knew she was nervous and toxic, but nothing the matter with her mind. . . . She has been sick and ailing ever since she left your place, but able to be around, only no vitality, and of a very nervous and temperamental temperament." The patient was later admitted to a sanitarium and died there.

Case 17.—Stenographer; aged twenty-four; single. Depressive reaction type with schizophrenic features. Unimproved. The patient was *taken home by her mother, who said that she* would never get well at the clinic and *might as well die at home.* The patient was later admitted to a psychopathic hospital. Diagnosis there: dementia praecox, catatonic.

Case 18—Man; aged thirty-five; married; no occupation. Epileptic psychosis. Unimproved. The patient's *wife* was advised to place the patient in a state hospital, but she *determined to take him home when she learned that his own family would care for him at their home, if she did not.* The patient became gradually worse and had to be committed to a state hospital. The family is indignant because the patient's wife will not care for him at home.

Case 19.—Banker; aged forty-seven; married. Organic reaction type (arteriosclerosis). Unimproved. The *patient refused to stay on account of his wife's attitude; for example, jealousy of the nurse* (tried to get patient to complain about her in order to have her dismissed) and insinuations about the nurse, nagging of her husband, going to the ward without permission when requested to limit visits, listening outside of patient's door to conversations between nurse and patient and doctor and patient, and the like. A year and a half after leaving the clinic the patient wrote: "Health excellent; steadily at work; never felt better in my life, in every way."

Case 20.—Sheet-metal worker; aged thirty-two; married. Paranoid reaction type. Unimproved. *The patient was morbidly suspicious of his wife* and insisted on leaving. The family was strongly advised to commit him to a state hospital and not to take him home. Even when the wife and sister came for the patient, he became suspicious when the wife talked with the physician in his office and said: "What is she doing there?" *He was taken home against advice. Two days after discharge, he shot his wife several times* in the neck and hand. She was in a serious condition, but recovered. The patient was admitted to a state hospital.

Case 21.—Factory worker (woman); aged twenty-three; single. Depressive reaction type. Improved. The patient chafed under the hospital régime and was taken home by her mother and sister. About a month later she was brought back for readmission and a state hospital was advised; but she was taken to Washington to visit instead. Her condition grew worse. *The family was convinced that the patient was under a "spell"* and planned to take her to various women who could cure spells. A report three months later stated that the patient *went to numerous doctors, clairvoyants, and women who remove spells.* She was finally admitted to a state hospital.

Case 22.—Housewife; aged nineteen; married. Husband a carpenter. Anxiety neurosis with tension and tendency to invalidism. Improved. The patient was taken out by her husband to go home. Shortly after, the patient reported: "Not feeling very well yesterday, but now am taking Lydia Pinkham's Vegetable Compound. Do you ever think I will get well?" A report four years later: After leaving the clinic the

patient tried several doctors without improvement and finally *spent five weeks in a "hospital", where the colored doctor told her she would never be well until she had a child.* The patient still complains of forgetfulness and lack of concentration.

Case 23.—Married woman; aged forty-one. Husband an electrician. Recurrent depression. Unimproved. Her *husband took the patient away* from the hospital to stay with the family at home. The patient stated on leaving that she had been well taken care of in the clinic and had learned a good lesson—how foolish it was to take her own life. (She had made many suicidal attempts before entering the clinic.) *One week after discharge, however, the patient attempted suicide* by choking herself and by trying to swallow hairpins. She was committed to a state hospital.

Case 24.—Draftsman; aged twenty-nine; married. Alcoholic hallucinosis with schizophrenic features. Slightly improved. The patient was very restless, and his *father encouraged him in his desire to go home.* Report the next year: The patient's wife felt that the patient should be in an institution, but his father insisted that he remain at home. *Since the father furnished the support for the family, the wife did not feel that she could take independent action* in the matter. She cried when telling this, saying that the patient was brought home against her wish. *The patient* had recently *twice threatened to shoot his wife.* He was finally committed to a state hospital. Diagnosis: paranoid dementia praecox. The patient was unhappy there and was taken home by his father after several weeks. The father "could not stand it". The father says that the patient's wife is quarrelsome and "nags her husband to death. I am more afraid of her than of him; he would never hurt any one."

Case 25.—Housewife; aged thirty; married. Husband a laborer. Schizophrenic reaction type. Constitutional inferior. Unimproved. The patient was taken home by her husband. On one occasion during the husband's visit, which lasted through the patient's supper time, he became disturbed when the nurse was urging the patient to eat. The patient whimpered and protested, but ate with no special resistance when food was put into her mouth. Her *husband interfered. He said that she had always been difficult to feed and our expecting her to eat was all wrong. It would make her sick.* Three years later the patient stated that she was well.

Case 26.—Housewife; aged twenty-two; married. Confusional state (toxic). Etiology not determined. Improved. *The patient was taken home by her husband, no reason being given.* Following discharge, the patient boarded with her parents. Her husband preferred this as he was "still afraid of her and wanted to feel sure that she was all right before going to housekeeping again". While admitting the strange behavior of the patient, both her husband and her family refused hospital care, but had a private physician until a year later. At that time *the patient's mother-in-law reported that the patient had been brought to her home by the patient's own father, who refused to keep her. The patient's back was black and blue from their beatings in effort to control*

her. The family was so afraid of her that they locked their doors at night. The patient was committed to a state hospital; paroled improved shortly after. Diagnosis: dementia praecox, simple type.

Case 27.—Housewife; aged thirty-seven; married. Husband in the insurance business. Schizophrenic reaction type with some hysterical features. Unimproved. *Her husband said that the chief reason for taking the patient home was that she felt that the medicine and treatment she had received were responsible for her nervous breakdown. After leaving* the clinic, the patient was at home for a month and was then *taken to an osteopathic sanitarium because she threatened to kill the children.* She remained there six months and was greatly improved. She still complained of noises in her head and could "almost hear voices" at times. She gained no insight into her delusions concerning the hospital.

Case 28.—Schoolboy; aged fifteen; single. Constitutional psychopathic personality. Unimproved. *The mother of the patient had been in the clinic several years before. Diagnosis: depression; paranoid personality. She got excited and criticized the methods and personnel before the patient.* She demanded his release because "she cannot trust the nurses and orderlies on the ward". She took him out in an ambulance, but would not say where. A report three months later stated that the patient had been taken ill in a cell at the police station, and was operated on at a general hospital for acute appendicitis. He had been arrested two days before because he had been seen loitering around the wharves for several nights. He said that he was trying to get aboard one of the boats to run away from home. Five months later he packed up his possessions and many belongings of other people and disappeared. There was no trace of him for months. Found and brought back home, he soon *attacked his father with a carving knife* and cut him from forehead to throat. He was placed on the quiet ward of a state hospital. There he jammed another patient's hat down over his face so hard it took two men to pull it off. He was placed in the disturbed ward. *He escaped from the state hospital.* Found six months later and returned to the state hospital, he *escaped again and was not found at the last report* (1926).

Case 29.—Laborer; aged twenty-one; single. Manic-depressive reaction type, manic phase. Improved. The patient was taken home by his mother, no reason being given. A year later the patient was reported as quite well since leaving the clinic. The patient said: "Haven't had any notions since I left, but I still bite my finger nails." The family is very superstitious. *His mother hints that a spell had been cast on the patient by some girl:* "Such things do happen—just a few days ago a girl threw a bottle overboard that had needles and pins in it."

Case 30.—Housewife; aged forty; separated from her husband. Paranoid flurry in constitutional psychopathic personality. Unimproved. No reason was given for leaving the hospital. A report two years later: After leaving the clinic the patient spent some months with her sister. She went to a *faith healer, "not the one who had cast a spell on her",* and he *soon cured her of all her complaints.*

Case 31.—Housewife; aged thirty-seven; married. Constitutional psychopathic personality. Depressive reaction with anxiety. Slightly improved. On account of the *paranoid condition of her husband* and in view of troublesome conditions caused by him, it was suggested that the patient be admitted to a state hospital. The husband disregarded this advice and took the patient home, despite the fact that he was warned of the patient's three suicidal attempts and her present suicidal tendencies. The *following year* a letter was received from the husband, telling of a *suicidal attempt* with "bichloride or some other such junk". The patient was later admitted to a sanitarium.

Case 32.—Housewife; aged forty; married. Agitated depression. Improved. When alone, she was often very restless, pacing the floor and muttering to herself under her breath, "Oh, my God!" When this was discussed with her, she explained that it was the distress of being kept in the clinic. Her *husband* was advised to place her in another hospital. The suicidal risks were explained to him, but he felt that he was *willing to take the risk at home* on the chance that removal from the hospital might produce an improvement. A letter from the patient's husband brought word that the patient had died about nine months after discharge: "For a short while after leaving the hospital she seemed to have sufficient grip on herself to come out of it. But she *gradually began to starve herself* and kept this up until she was very thin and had very little strength. Some way or another *she managed to obtain a bottle of veronal.* Of course she took all ten tablets at once. Although she had taken as much several times during her illness, she was in such a weakened condition this time that it *proved too much for her heart.* . . . If she could not recover at Johns Hopkins Hospital, we felt that no hospital could help her much. Her death was a great relief to her long mental suffering of over two years."

Case 33.—Secretary; aged twenty-seven; single. *Schizophrenic reaction type with catatonic stupor episodes.* Unimproved. For several weeks before discharge the patient had been insisting upon leaving and she promised her family to do anything and everything they said. The *family physician reported a year later: Saw the patient the day after her discharge* and *was "amazed". She seemed mentally "perfectly clear and marvelously well".* Mental condition has continued good and behavior normal. She has not attempted to work yet.

Case 34.—Schoolgirl; aged sixteen; single. Constitutional psychopathic inferiority. Unimproved. The patient had been *"admitted after a number of sex delinquencies.* Her *mother took her home* instead of to another institution, as advised. A report the following year yielded the following information: After six weeks the patient ran away from home. She was *found in another city in a disorderly house.* She had *married a shady individual much older than herself.* She was taken to a corrective institution. There she seemed to make excellent progress, but her *mother took her home again against the advice of physicians.*

SUMMARY

1. The ever wider extension of psychopathology into the field of the social sciences makes it the duty of psychiatry to investigate the social problems that are most closely related to the narrower field of psychiatry.

2. During a period of eight years (1918–1926), 2,758 patients were discharged from the Henry Phipps Psychiatric Clinic, Johns Hopkins Hospital, according to medical routine. During the same period 193 patients, or 6.54 per cent of the total discharges, were discharged against medical advice.

3. As regards the distribution of diagnoses in these cases, there is a predominance of depressions (73) and a relatively large number of cases of general paresis (17). Manic excitement (4) and paranoid psychosis (2) are infrequent. This would indicate that the social environment of a patient does not easily recognize the milder manifestations of depression as morbid. In elated conditions, on the other hand, the environment takes a very serious view of the patient's condition. The large number of cases of general paresis is connected with the fact that, due to its characteristic symptomatology, the patient and his environment frequently have little insight into the seriousness of the condition.

4. In 146 of 193 cases, the attitude of the family was the main problem of the physician, as compared with 26 cases in which the initiative could be solely and entirely attributed to the patient. In 10 cases the patient was taken from the clinic by his family expressly against his wishes.

5. In a very considerable number of cases the reasons given by the family had very little to do with the patient's sickness and treatment, except in so far as it caused a separation of the patient from his family. For example, a husband wanted his wife at home because the baby disturbed him by crying at night; and so forth.

6. In a number of cases there was a division in the family—most frequently in the form of husband vs. wife's relatives and vice versa. This division should receive the attention of the physician even before the emergency of the discharge against advice brings it especially to his notice.

7. Out of 172 patients from whom information as to their

further career was obtained, 64 had apparently made satisfactory adjustment outside of mental hospitals (satisfactory being, of course, a very relative statement); 60 were readmitted to mental hospitals; 8 committed suicide; 6 made homicidal attempts; 8 made suicidal attempts.

8. The fact that a difference in opinion often arises between the physician and the layman on the occasion of discharges against medical advice should make it the duty of the physician to explain to the family the psychopathological condition, the treatment, and the social consequences much more clearly than is done customarily.

9. In some cases the further fate of the patient did not bear out the prognosis made by the physician. This should be a warning against too fixed and formal prognoses as against a careful evaluation of the social environment to which the patient returns (social prognosis). In a few cases what seemed from the physician's point of view an undesirable discharge proved salutary—for example, the case of a woman suffering from a diagnostically unclear auditory hallucinosis, which cleared up when the patient was precipitated at home into a situation demanding great activity. On the whole, the dangers of discharge against advice seem to be overestimated.

10. It is indicated by the findings of this study that in its social aspect mental disease is not a problem only of the individual and the community in general; between them the family is interpolated as a decisive entity. In general, the statement seems justifiable that when the relationship between the family and the physician comes to be regarded as forming an essential part of psychopathology, the extension of the organization of psychiatric hospitals with wards for only voluntary admissions seems practicable and desirable.

RECENT STATISTICS OF ALCOHOLIC MENTAL DISEASE

HORATIO M. POLLOCK

Director, Statistical Bureau, New York State Department of Mental Hygiene

FREDERICK W. BROWN

Director, Department of Information and Statistics, The National Committee for Mental Hygiene

IN view of the widespread interest in the enforcement of the prohibition laws and in the liquor problem in general, the authors have deemed it wise to supplement and bring up to date as nearly as possible the data contained in a study on prohibition and alcoholic mental disease by Horatio M. Pollock and Edith M. Furbush, which was published in *The American Review* and in MENTAL HYGIENE in 1924.[1]

In preparing this supplementary study, data have been compiled from three principal sources, namely: The Statistical Bureau of the New York State Department of Mental Hygiene, the Department of Information and Statistics of The National Committee for Mental Hygiene, and the Federal Census Bureau. The data at each source were compiled from original schedules filled out in accordance with uniform instructions by the reporting institutions.

ALCOHOLIC MENTAL DISEASE IN NEW YORK STATE

The Statistical Bureau of the New York State Department of Mental Hygiene has collected in uniform manner data relating to alcoholic mental disease and the use of alcohol by first admissions to the civil state hospitals each year since 1909.

The record with respect to new cases of alcoholic mental disease in relation to all first admissions is shown in Table 1. The twenty years covered by this table may, with

1 "Prohibition and Alcoholic Mental Disease", by Horatio M. Pollock and Edith M. Furbush. *The American Review*, Vol. 2, pp. 142–54, March-April, 1924, and MENTAL HYGIENE, Vol. 8, pp. 548–70, April, 1924.

reference to the trend of the alcoholic cases, be separated into four rather distinct periods. The first period includes the years 1909–1913, when the new alcoholic cases numbered

TABLE 1. NEW CASES OF ALCOHOLIC MENTAL DISEASE ADMITTED TO CIVIL STATE HOSPITALS OF NEW YORK, 1909-1928

FISCAL YEAR ENDED	TOTAL NEW CASES, ALL PSYCHOSES	NEW CASES OF ALCOHOLIC MENTAL DISEASE					
		Number			*Per cent of all new cases*		
		Males	Females	Total	Males	Females	Total
1909	5,222	433	128	561	15.6	5.8	10.8
1910	5,564	452	131	583	15.3	5.0	10.5
1911	5,700	444	147	591	14.7	5.5	10.4
1912	5,742	434	131	565	14.4	4.8	9.8
1913	6,061	438	134	572	13.7	4.7	9.4
1914	6,265	348	116	464	10.4	3.6	7.4
1915	6,204	255	90	345	7.8	3.1	5.6
1916*	4,903	215	82	297	8.4	3.5	6.1
1917	6,877	437	157	594	12.1	4.8	8.6
1918	6,797	257	97	354	7.3	3.0	5.2
1919	6,791	204	65	269	5.8	2.0	4.0
1920	6,573	90	32	122	2.7	1.0	1.9
1921	6,939	167	26	193	4.6	0.8	2.8
1922	7,015	194	32	226	5.1	1.0	3.2
1923	6,900	220	56	276	6.1	1.7	4.0
1924	6,933	302	71	373	8.2	2.2	5.4
1925	7,435	341	81	422	8.8	2.3	5.7
1926	7,295	333	89	422	8.4	2.7	5.8
1927	7,928	440	114	554	10.1	3.2	7.0
1928	8,614	430	79	509	9.1	2.0	5.9

*9 Months.

from 561 to 591, and the percentages varied from 9.4 to 10.8. The second period covered the years 1914–1917, during the first three of which there was a decided reduction in the number and percentage of the alcoholic cases. In the year 1917 a reaction occurred, probably due to the entrance of this country into the World War. The number of alcoholic first admissions in that year was 594, the largest number in the history of the New York State hospital system. The third period, running from 1918 to 1921, witnessed a remarkable decline in alcoholic cases. The low point was reached in 1920, when the number was only 122 and the percentage 1.9. The fourth and final period covers the years from 1922

to 1928. In this period the trend of alcoholic cases has been upward, but a slight downward reaction occurred in 1928. Whether such reaction is the beginning of a new trend or merely a slight divergence in the upward movement will be later revealed.

Although there are comparatively few women in the alcoholic group, the decline among them since 1910 has been relatively greater than among men.

The influence of alcohol in the causation of mental disease of various kinds is indicated, to some extent at least, by the percentage of intemperate users of alcohol among first admissions. A record of such use has been regularly made by the state hospitals on statistical schedules since 1909. Data compiled directly from such schedules for the past twenty years are set forth in Table 2.

TABLE 2. INTEMPERATE USE OF ALCOHOL AMONG FIRST ADMISSIONS TO CIVIL STATE HOSPITALS OF NEW YORK, 1909-1928

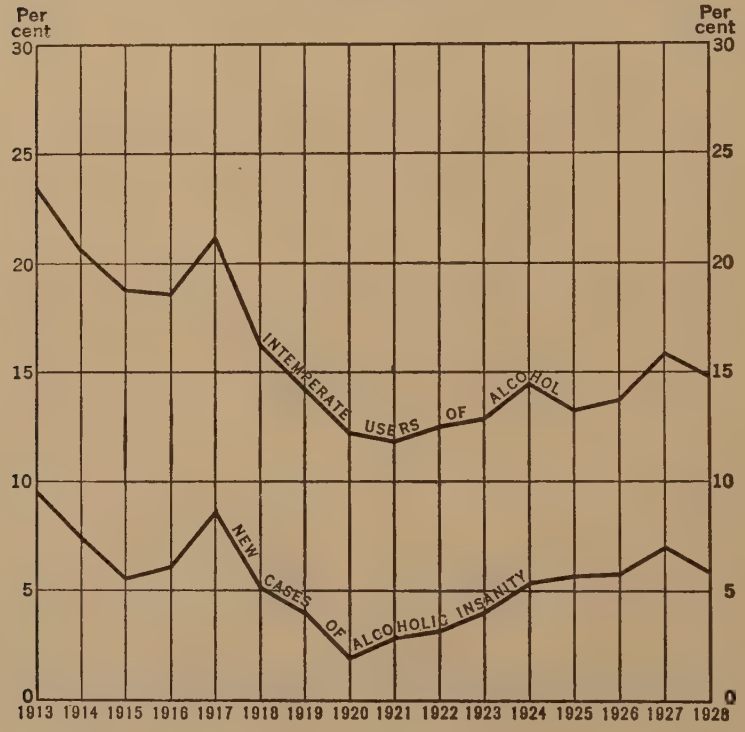
FISCAL YEAR ENDED	INTEMPERATE USERS OF ALCOHOL					
	Number			*Per cent of total first admissions*		
	Males	Females	Total	Males	Females	Total
1909	1,229	369	1,598	44.2	15.1	28.7
1910	*1,684	*488	*2,172	56.9	28.7	38.1
1911	1,082	302	1,384	35.9	11.2	24.3
1912	1,097	273	1,370	36.5	10.0	23.8
1913	1,103	318	1,421	34.6	11.1	23.5
1914	1,027	258	1,285	30.8	8.8	20.5
1915	939	225	1,164	28.8	7.5	18.7
1916 (9 months)	725	182	907	28.2	7.8	18.5
1917	1,152	300	1,452	32.0	9.2	21.1
1918	851	253	1,104	24.1	7.7	16.2
1919	804	161	965	22.8	4.9	14.2
1920	684	119	803	20.3	3.7	12.2
1921	691	131	822	18.9	4.0	11.8
1922	757	122	879	21.1	3.8	12.5
1923	756	130	886	20.9	4.0	12.8
1924	842	165	1,007	22.8	5.1	14.5
1925	813	167	980	21.0	4.5	13.2
1926	832	170	1,002	21.0	5.1	13.7
1927	1,050	211	1,261	24.1	5.9	15.9
1928	1,094	191	1,285	23.2	4.9	14.9

*Includes moderate drinkers.

The trends shown in this table correspond closely with those shown in Table 1, although the variations from period to period are relatively not quite so marked. This is well shown in Chart 1 which covers the years 1913 to 1928. The dip in the trends in 1928 may or may not be significant.

CHART 1

CASES OF ALCOHOLIC MENTAL DISEASE AND INTEMPERATE USERS OF ALCOHOL AMONG NEW ADMISSIONS TO NEW YORK CIVIL STATE HOSPITALS, 1913–1928



ALCOHOLIC MENTAL DISEASE IN 19 STATES

In their study of prohibition and alcoholic mental disease,[1] Pollock and Furbush made use of the uniform statistical reports received by The National Committee for Mental Hygiene for the year 1922. These reports were received from 98 state hospitals for mental disease, distributed as follows:

[1] Op. cit.

California	6	New Jersey	2
Colorado	1	New York	15
Connecticut	2	Ohio	8
Georgia	1	Oregon	1
Illinois	9	Pennsylvania	6
Indiana	4	Rhode Island	1
Iowa	4	South Carolina	1
Louisiana	2	South Dakota	1
Maine	2	Tennessee	1
Maryland	2	Texas	1
Massachusetts	13	Vermont	1
Michigan	5	Virginia	3
Mississippi	1	Washington	1
Nebraska	2	Wyoming	1
New Hampshire	1		

For that study complete data—that is, reports from every state hospital in the state—were received from 19 states, having a total of 80 hospitals.

In the present study, data for the same group of hospitals for the years 1925 and 1926 are compared with those for 1922, and data from smaller groups are compared with those for states from which complete returns were available for the years 1910, 1919, and 1921.

As stated in the previous study, "the wide geographical distribution, the fact that the group of hospitals is unselected, and the large number of patients included, make the data representative of the country as a whole".

New Admissions to State Hospitals. — The term "new admissions" refers to all patients admitted for the first time to any hospital for the treatment of mental disease, except institutions for temporary care only.

Detailed figures showing the number of males and females, the total number of all new admissions, and the rate of new admissions per 100,000 of the general population of each of the 19 states, for the years 1922, 1925, and 1926, are given in Table 3 (page 596). These figures may be summarized as follows:

			Total	
Year	*Males*	*Females*	Number	Rate per 100,000
1922	16,807	12,408	29,215	50.5
1925	16,842	12,835	29,677	48.5
1926	16,855	12,683	29,538	47.6

TABLE 3. NUMBER OF NEW ADMISSIONS TO STATE HOSPITALS FOR MENTAL DISEASE AND RATE PER 100,000 GENERAL POPULATION IN 19 STATES FOR THE YEARS 1926, 1925 AND 1922.

States	1926				1925				1922			
			Total				Total				Total	
	Males	Females	Number	Rate per 100,000	Males	Females	Number	Rate per 100,000	Males	Females	Number	Rate per 100,000
California	1,782	1,097	2,879	66.7	1,940	1,030	2,970	71.1	1,773	947	2,720	73.6
Colorado	241	152	393	37.1	210	145	355	34.1	264	159	423	43.3
Connecticut	552	388	940	58.4	451	375	826	52.6	464	399	863	59.6
Georgia	476	478	954	30.4	520	434	954	30.8	335	317	652	22.0
Illinois	2,768	1,619	4,387	60.9	2,754	1,674	4,428	62.4	2,970	1,822	4,792	71.5
Iowa	536	333	869	35.9	515	412	927	38.3	531	393	924	37.7
Louisiana	313	249	562	29.3	291	257	548	28.8	317	272	589	32.1
Maine	186	172	358	45.5	217	156	373	47.4	210	120	330	42.6
Massachusetts	1,455	1,359	2,814	67.0	1,520	1,344	2,864	69.1	1,743	1,531	3,274	82.3
New Hampshire	203	155	358	78.9	166	172	338	74.9	186	130	316	70.8
New Jersey	719	549	1,268	34.5	781	624	1,405	39.0	732	618	1,350	40.7
New York	4,091	3,337	7,428	65.7	4,004	3,580	7,584	67.9	3,922	3,247	7,169	66.9
Ohio	1,769	1,349	3,118	47.2	1,703	1,279	2,982	46.1	1,650	1,027	2,857	47.5
Pennsylvania	997	788	1,785	18.6	980	725	1,705	18.0	888	671	1,559	17.3
Rhode Island	198	196	394	56.9	212	156	368	54.2	201	143	344	55.5
South Carolina	317	284	601	32.9	296	315	611	33.9	371	278	649	37.6
South Dakota	129	95	224	32.5	159	74	233	34.2	117	82	199	30.6
Vermont	89	62	151	42.9	91	66	157	44.6	89	57	146	41.4
Wyoming	34	21	55	23.4	32	17	49	21.4	44	15	59	28.5
Total	16,855	12,683	29,538	47.6	16,842	12,835	29,677	48.5	16,807	12,408	29,215	50.5

A very slight increase is noted among the males, there being 35 more in 1925 than in 1922 and 13 more in 1926 than in 1925. Among the females there was an increase of 427 from 1922 to 1925, and a decrease of 142 from 1925 to 1926. The net increase from 1922 to 1925 was, therefore, 48 males and 285 females, or a total of 333, the increase in females being approximately six times that of the males. There were 133 males to every 100 females among the new admissions in 1926, the ratio being considerably larger than that of males to females in the general population, which the last census gave as 104 males to every 100 females. Between 1922 and 1926 there was an increase in the number of male new admissions in 10 states, and in the number of female in 12.

The extent of state institutional care of persons suffering from mental disease is best indicated by the rate per 100,000 of general population. For the entire group of states this rate decreased by 2.0 from 1922 to 1925 and by 0.9 from 1925 to 1926, a total decrease of 2.9 from 1922 to 1926. The seven states having the highest rate per 100,000 were New Hampshire, Massachusetts, California, New York, Illinois, Connecticut, and Rhode Island. In all of these states more than 60 per cent of the population live in urban districts. The lowest rates, on the other hand, occur in those states whose population is predominantly rural. Pennsylvania, whose rate per 100,000 in the table is the lowest of all the states in each of the three years, must be considered separately, in as much as a great many of its mental patients are cared for in county institutions.

Cases of Alcoholic Mental Disease Among New Admissions.—The number of new cases of alcoholic mental disease and the per cent they constitute of all new admissions to the hospitals of 19 states are given in Table 4 (page 598). The percentages for males and females indicate percentages of all new male and female admissions respectively. The total figures and the percentages for the entire group of states are:

	Number			*Per cent*		
Year	Males	Females	Total	Males	Females	Total
1922	1,027	124	1,151	6.1	1.0	3.9
1925	1,279	182	1,461	7.6	1.4	4.9
1926	1,369	206	1,575	8.1	1.6	5.3

TABLE 4. CASES OF ALCOHOLIC INSANITY AMONG NEW ADMISSIONS TO THE STATE HOSPITALS FOR MENTAL DISEASE IN 19 STATES FOR THE YEARS 1926, 1925, AND 1922.

STATE	NEW CASES OF ALCOHOLIC INSANITY																	
	1926						1925						1922					
	Number			*Per cent of all new admissions*			*Number*			*Per cent of all new admissions*			*Number*			*Per cent of all new admissions*		
	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T
California	108	18	126	6.1	1.6	4.4	116	12	128	6.0	1.2	4.3	109	10	119	6.1	1.1	4.4
Colorado	1	...	1	0.4	...	0.3	2	...	2	0.9	...	0.6	3	...	3	1.1	...	0.7
Connecticut	71	11	82	12.9	2.8	8.7	54	7	61	12.0	1.9	7.4	40	1	41	8.6	0.3	4.8
Georgia	14	...	14	2.9	...	1.5	11	1	12	2.1	0.2	1.3	5	1	6	1.5	0.3	0.9
Illinois	270	28	298	9.8	1.7	6.8	223	26	249	8.1	1.6	5.6	224	28	252	7.5	1.5	5.3
Iowa	26	...	26	5.0	...	3.0	30	3	33	6.0	0.7	3.6	24	2	26	4.5	0.5	2.8
Louisiana	2	...	2	0.6	...	0.4	1	3	4	0.3	1.2	0.7	5	...	5	1.6	...	0.8
Maine	11	...	11	5.9	...	3.1	18	1	19	8.3	0.6	5.1	14	...	14	6.7	...	4.2
Massachusetts	161	25	186	11.1	1.8	6.6	158	17	175	10.4	1.3	6.1	180	35	215	10.3	2.3	6.6
New Hampshire	15	2	17	7.4	1.3	4.7	11	1	12	6.6	.6	3.6	19	2	21	10.2	1.5	6.6
New Jersey	70	3	73	9.7	0.5	5.8	80	8	88	10.1	1.3	6.3	50	5	55	6.8	0.8	4.1
New York	343	89	432	8.4	2.7	5.8	347	82	429	8.7	2.3	5.7	209	32	241	5.3	1.0	3.4
Ohio	133	17	150	7.5	1.3	4.8	103	7	110	6.0	0.5	3.7	60	4	64	3.6	0.3	2.2
Pennsylvania	82	6	88	8.2	0.8	4.9	67	4	71	6.8	0.6	4.2	42	1	43	4.7	0.1	2.8
Rhode Island	44	5	49	22.2	2.6	12.4	39	8	47	18.4	5.1	12.8	32	2	34	15.9	1.4	9.9
South Carolina	9	...	9	2.8	...	1.5	7	...	7	2.4	...	1.1	5	1	6	1.3	.4	0.9
South Dakota	4	...	4	3.1	...	1.8	4	...	4	2.5	...	3.0	2	...	2	1.7	...	1.0
Vermont	1	...	1	1.1	...	1.6	3	...	3	3.3	...	1.9	1	...	1	1.1	...	0.7
Wyoming	4	2	6	11.8	9.5	10.9	5	2	7	15.6	11.8	14.3	3	...	3	6.8	...	5.1
Total	1,369	206	1,575	8.1	1.6	5.3	1,279	182	1,461	7.6	1.4	4.9	1,027	124	1,151	6.1	1.0	3.9

These figures show a small, but significant increase in both the number and percentage of alcoholic cases among new admissions.

The ratio of male to female patients with alcoholic psychoses is of interest. In 1922 there were approximately 6 males to every female; in 1925 the ratio was practically the same; and in 1926 it increased to approximately 7.5 to 1.

Within the different states considerable variation is to be noted in the percentages of alcoholic cases, ranging in 1922 from 9.9 per cent in Rhode Island to 0.7 per cent in Colorado and Vermont; in 1925, from 14.3 per cent in Wyoming to 0.6 per cent in Colorado; and in 1926, from 12.4 per cent in Rhode Island to 0.3 per cent in Colorado. Similar wide variations occur among the male and female patients, there being several states with no female alcoholic patients.

It is also of interest to note that by far the largest number of alcoholic patients are in states predominantly urban in their population. The 1920 Federal Census gives the following percentages of urban population for the states noted: California, 68; Connecticut, 67.7; Illinois, 67.9; Massachusetts, 94.8; New Jersey, 78.4; New York, 82.7; Ohio, 63.8; Pennsylvania, 64.3; and Rhode Island, 97.5. These states have more than 90 per cent of both the male and female alcoholic cases.

A further comparison of the individual states indicates that alcoholic psychoses are much more prevalent in those states that were "wet" before the national prohibition law went into effect than in those that were "dry". Of the 9 states just listed as having more than 90 per cent of all alcoholic cases, all were "wet" before prohibition, while all of the others, with the single exception of Vermont,[1] were either "bone dry" or had state-wide restrictions on the sale and use of alcoholic beverages which placed them in the "dry" column.

Alcoholic Cases Among All Admissions.—A comparison of the percentages of alcoholic cases among all admissions for 1926, 1925, 1922, and 1910, including readmissions as well as those admitted for the first time, is made possible by the use of data furnished by the Federal Census Bureau for

1 Vermont was dry part of the time before prohibition.

1910. Although the 1910 survey includes figures for private as well as state hospitals, their influence is so slight as to affect the comparison very little if at all. These percentages for the 19 states are as follows:

State	*1926*	*1925*	*1922*	*1910*
California	4.2	4.2	4.3	13.0
Colorado	0.2	0.5	0.7	20.8
Connecticut	9.2	6.8	4.8	10.6
Georgia	1.4	1.3	0.9	5.1
Illinois	6.4	5.9	5.1	8.9
Iowa	1.0	1.4	3.0	6.9
Louisiana	0.4	0.6	0.7	8.1
Maine	3.4	4.8	4.0	6.5
Massachusetts	6.2	6.3	6.4	14.6
New Hampshire	4.7	3.4	6.6	11.3
New Jersey	5.8	6.6	4.3	19.7
New York	5.4	5.3	3.2	11.5
Ohio	4.6	3.7	2.1	12.4
Pennsylvania	4.6	4.3	3.0	6.9
Rhode Island	11.7	12.4	9.8	11.4
South Carolina	1.3	1.2	0.8	5.7
South Dakota	1.4	1.3	0.8	0.5
Vermont	1.9	1.3	1.5	11.1
Wyoming	8.2	11.1	5.8	14.3
Total	5.1	4.8	3.9	11.0

It will be noted that for the entire group the percentage dropped from 11.0 in 1910 to 3.9 in 1922, and that since 1922 there has been a slight increase, the 1926 percentage, however, being less than one-half that of 1910. The percentages for the three years 1926, 1922, and 1910, are further compared in Chart 2 (page 601).

Prevalence of Alcoholic Mental Disease. — The actual prevalence of alcoholic mental disease is probably best indicated by the number of alcoholic psychoses per 100,000 of general population. A comparison of the number of new cases per 100,000 of general population for the years 1919, 1922, 1925, and 1926 should indicate the general trend of the disease since the advent of prohibition. Complete data for these four years were received from 12 states, comprising 43 hospitals. The number of alcoholic cases among the new admissions to the hospitals of these states and the rate per

CHART 2

CASES OF ALCOHOLIC INSANITY AMONG ALL ADMISSIONS TO THE HOSPITALS FOR MENTAL DISEASE IN 19 STATES DURING 1910, 1922, AND 1926

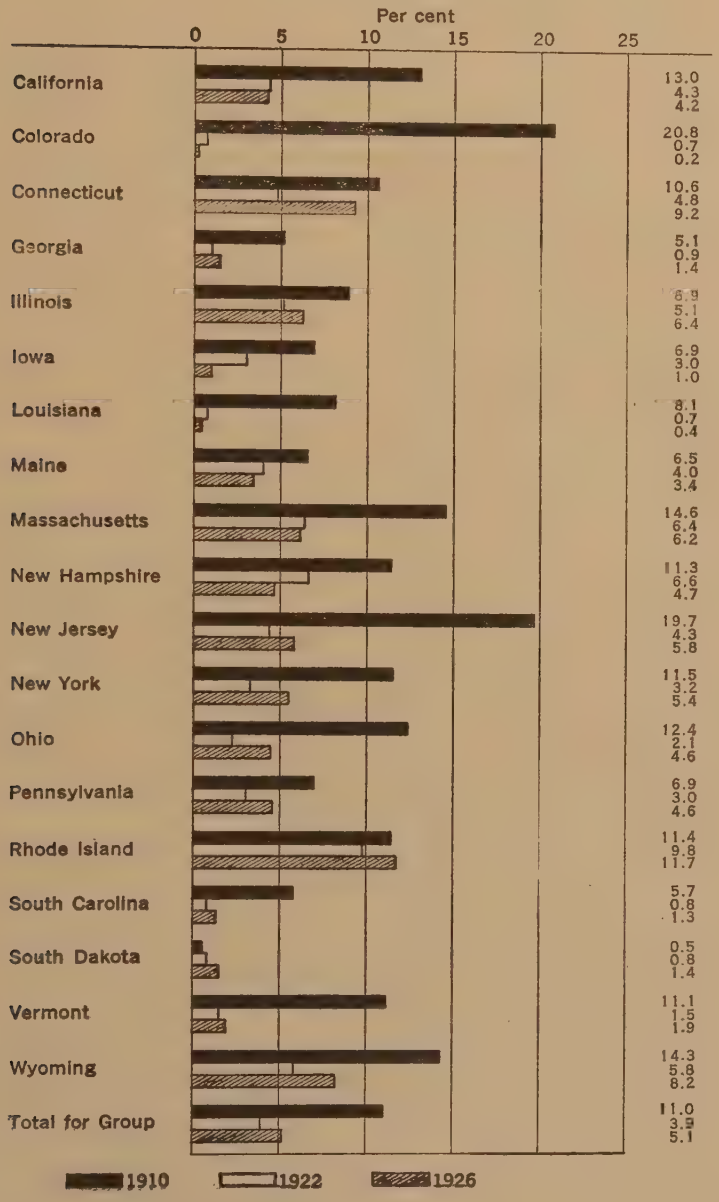


TABLE 5. NUMBER OF NEW CASES OF ALCOHOLIC INSANITY AND RATE PER 100,000 OF GENERAL POPULATION IN 12 STATES FOR THE YEARS 1926, 1925, 1922, AND 1919.

STATE	1926				1925				1922				1919			
			Total				*Total*				*Total*				*Total*	
	Males	*Females*	Number	Rate per 100,000	*Males*	*Females*	Number	Rate per 100,000	*Males*	*Females*	Number	Rate per 100,000	*Males*	*Females*	Number	Rate per 100,000
Colorado	1	0	1	0.1	2	0	2	0.2	3	0	3	0.3	2	0	2	0.2
Georgia	14	0	14	0.4	11	1	12	0.4	5	1	6	0.2	9	0	9	0.3
Iowa	5	0	5	0.2	12	1	13	0.5	24	2	26	1.1	25	1	26	1.1
Maine	11	0	11	1.4	18	1	19	2.4	14	0	14	1.8	17	1	18	2.3
Massachusetts	161	25	186	4.4	158	17	175	4.2	180	35	215	5.4	241	54	295	7.7
New Hampshire	15	2	17	3.7	11	1	12	2.7	19	2	21	4.7	15	1	16	3.6
New Jersey	70	3	73	2.0	80	8	88	2.4	50	5	55	1.7	77	7	84	2.7
New York	343	89	432	3.8	347	82	429	3.9	209	32	241	2.2	216	69	285	2.8
Rhode Island	44	5	49	7.1	39	8	47	7.0	32	2	34	5.5	17	2	19	3.2
South Carolina	9	0	9	0.5	7	0	7	0.4	5	1	6	0.3	6	0	6	0.4
South Dakota	4	0	4	0.6	4	0	4	0.6	2	0	2	0.3	0	0	0	0.0
Vermont	1	0	1	0.3	3	0	3	0.9	1	0	1	0.3	2	0	2	0.6
Total	678	124	803	2.6	692	119	811	2.7	544	80	624	2.2	627	135	762	2.7

100,000 of general population are given in Table 5 (page 602), which may be here summarized:

Year	Males	Females	Total	
			Number	Rate per 100,000
1919	627	135	762	2.7
1922	544	80	624	2.2
1925	692	119	811	2.7
1926	678	124	803	2.6

From 1919 to 1922 a decrease of 138 in the total number and of 0.5 in the rate per 100,000 is noted; from 1922 to 1925 the number of cases increased by 187 and the rate returned to 2.7 as in 1919; and a very slight decrease of 8 in number and 0.1 per cent in rate occurs between 1925 and 1926. The proportion of male to female cases for the four years respectively was 4.6 to 1 in 1919, 6.8 to 1 in 1922, 5.8 to 1 in 1925, and 5.5 to 1 in 1926. Both male and female cases decreased in 1922 and both increased in 1925 and again in 1926, but whereas the number of males in both 1925 and 1926 is greater than in 1919, the number of females in these two years is still less than in 1919. Numerous variations are noted in both numbers and rates for different states, those states with the largest urban population, Maine in 1925 excepted, having the highest rate. A comparison of the figures for 1926 and 1919 shows that one-half of the states—Georgia, New Hampshire, New York, Rhode Island, South Carolina, and South Dakota—have an increase in both number and rate and the others a decrease in both. Chart 3 (page 604) shows the comparative total rates per 100,000 of general population for the eight states with the largest number of alcoholic psychoses.

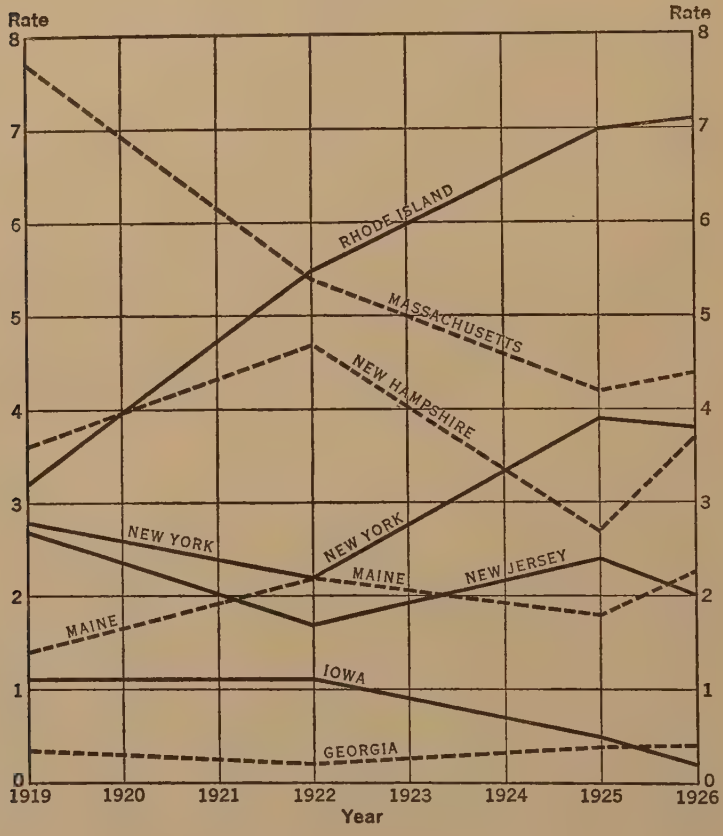
Intemperate Use of Alcohol.—Data concerning the number and per cent of intemperate users of alcohol among new admissions were received from 65 hospitals in 15 states for the years 1921, 1922, 1925, and 1926, and are given in Table 6 (page 605), the totals for the different years being as follows:

Year	Number			Per cent		
	M	F	T	M	F	T
1921	2,379	322	2,701	11.3	1.5	12.8
1922	2,647	357	3,004	11.9	1.6	13.5
1925	2,720	433	3,153	11.9	1.9	13.8
1926	2,774	452	3,226	12.2	2.0	14.2

A continual increase in both number and per cent is noted for each of the years for which data were obtained, except for the percentage of males in 1925, the states with a high percentage of urban population again furnishing the largest number, with the rural states of Colorado in 1921 and 1926,

CHART 3

RATE OF NEW CASES OF ALCOHOLIC MENTAL DISEASE PER 100,000 OF GENERAL POPULATION IN 8 STATES FOR THE YEARS 1919, 1922, 1925, AND 1926



Maine in 1921, 1922, and 1925, and South Carolina in 1921 and 1922 joining them. The marked variations that appear may be due, in some cases, to variations in methods of reporting the use of alcohol among new admissions.

The intemperate use of alcohol, while it is the direct cause of alcoholic psychoses, is likewise recognized as a contribut-

TABLE 6. INTEMPERATE USERS OF ALCOHOL AMONG ALL NEW ADMISSIONS TO THE 63 STATE HOSPITALS IN 15 STATES DURING 1926, 1925, 1922, AND 1921, BY SEX, NUMBER AND PER CENT OF ALL NEW ADMISSIONS.

STATE	1926						1925						1922						1921					
	Intemperate users of alcohol			*Per cent of all new admissions*			*Intemperate users of alcohol*			*Per centof all new admissions*			*Intemperate users of alcohol*			*Per cent of all new admissions*			*Intemperate users of alcohol*			*Per cent of all new admissions*		
	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T
California...	263	41	304	9.1	1.4	10.5	318	38	356	10.7	1.3	12.0	362	33	395	13.3	1.2	14.5	347	25	372	14.1	1.0	15.1
Colorado....	47	6	53	11.9	1.5	13.4	31	7	38	8.7	1.9	10.6	32	4	36	7.6	0.9	8.5	51	3	54	11.2	0.7	11.9
Connecticut.	174	24	198	18.5	2.6	21.1	129	34	163	15.6	4.1	19.7	151	17	168	17.5	2.0	19.5	131	18	149	16.0	2.2	18.2
Maine	38	2	40	10.6	0.6	11.2	57	6	63	15.3	1.6	16.9	53	6	59	16.1	1.8	17.9	49	7	56	12.3	1.8	14.1
Massachusetts	359	68	427	12.8	2.4	15.2	387	71	458	13.5	2.5	16.0	396	85	481	12.1	2.6	14.7	293	61	354	11.5	2.4	13.9
N.Hampshire	44	2	46	12.3	0.6	12.9	40	6	46	11.8	1.8	13.6	45	5	50	14.3	1.6	15.9	15	0	15	5.8	0.0	5.8
New Jersey .	187	30	217	14.8	2.4	17.2	189	27	216	13.5	1.9	15.4	121	15	136	9.0	1.1	10.1	80	9	89	6.2	0.7	6.9
New York...	867	171	1,038	11.7	2.3	14.0	868	169	1,037	11.4	2.2	13.6	820	126	946	11.4	1.8	13.2	758	133	891	10.7	1.9	12.6
Ohio.....	447	66	513	14.3	2.1	16.4	349	32	381	11.7	1.1	12.8	335	30	365	11.7	1.1	12.8	369	29	398	13.0	1.0	14.0
Pennsylvania	196	25	221	11.0	1.4	12.4	195	21	216	11.4	1.2	12.6	178	15	193	11.4	1.0	12.4	132	17	149	8.8	1.1	9.9
Rhode Island	75	11	86	19.0	2.8	21.8	76	13	89	20.7	3.5	24.2	57	8	65	16.6	2.3	18.9	52	8	60	15.8	2.4	18.2
S. Carolina..	35	0	35	5.3	0.0	5.3	37	1	38	6.1	0.2	6.3	35	11	46	5.4	1.7	7.1	50	8	58	6.8	1.1	7.9
S. Dakota...	16	1	17	7.2	0.5	7.7	17	1	18	7.3	0.4	7.7	20	0	20	10.1	0.0	10.1	25	1	26	13.0	0.5	13.5
Vermont....	16	3	19	10.6	2.0	12.6	15	3	18	9.6	1.9	11.5	30	1	31	20.5	0.7	21.2	18	2	20	12.9	1.4	14.3
Wyoming ...	10	2	12	18.2	3.7	21.9	12	4	16	24.5	8.2	32.7	10	1	11	17.0	1.7	18.7	9	1	10	14.3	1.6	15.9
Total.....	2,774	452	3,226	12.2	2.0	14.2	2,720	433	3,153	11.9	1.9	13.8	2,647	357	3,004	11.9	1.6	13.5	2,379	322	2,701	11.3	1.5	12.8

ing factor to certain other mental diseases. On the other hand, it is often a result, rather than a cause, of the disorder, while in many cases it is apparently nothing more than an accompanying condition, no cause-and-effect relationship being discernible. The extent of the prevalence of the intemperate use of alcohol among patients suffering from other forms of mental disease may be seen from an examination of the following summary derived from the data secured by the Federal Census Bureau for all state and private institutions for the year 1922. In this summary are given the total number of new admissions and the number and per cent of intemperate users of alcohol in each clinical group.

Psychoses	*Total number of new admissions*	*Intemperate users of alcohol*	
		Number	Per cent
Traumatic	229	28	12.2
Senile	6,845	378	5.5
With cerebral arteriosclerosis	3,438	351	10.2
General paralysis	6,294	1,049	16.7
With cerebral syphilis	893	123	13.8
With Huntington's chorea	97	6	6.2
With brain tumor	61	2	3.3
With other brain or nervous disease	643	61	9.5
Alcoholic	2,693	2,693	100.0
Due to drugs or other exogenous toxins	615	181	29.4
With pellagra	420	8	1.9
With other somatic diseases	1,806	93	52.0
Manic-depressive	11,393	544	4.8
Involution melancholia	1,803	56	3.1
Dementia praecox (schizophrenia)	15,526	932	6.0
Paranoia or paranoid conditions	1,881	128	6.8
Epileptic	1,813	114	6.3
Psychoneuroses and neuroses	2,777	110	4.0
With psychopathic personality	914	127	14.0
With mental deficiency	1,899	111	5.9
Undiagnosed	4,194	354	8.4
Without psychosis	5,157	1,640	31.8
Unknown	285	30	10.5
All clinical groups	71,676	9,119	12.7

Although the intemperate use of alcohol is here reported merely as an accompanying, rather than as an etiological factor, the high percentages occurring in certain of the

clinical groups are felt to be significant. In this connection the statement of Kraepelin[1] that alcohol was the direct cause of about one-third of all mental affections observed at Munich is of interest, as are also the percentages given by him. He states that "between November, 1904, and November, 1905, nearly one-half of the admissions to the Psychiatric Clinic at Munich were credited to alcohol; of the imbeciles, 42.9 per cent; of the epileptics, 65.1 per cent among the males, and 28.5 per cent among the females; of the manic-depressive cases, 43.5 per cent of the males; of traumatic psychoses, 23.1 per cent; in arteriosclerosis, 64 per cent of the male cases; and of the general paralytics, 51.9 per cent in men and 43.5 per cent in women". He further stated that "one-third of the cases of general paralysis, which is a syphilitic disease, could be avoided by eliminating alcohol".

Comparison of Rates.—Inasmuch as the rate per 100,000 of general population furnishes a very good index to the prevalence of mental disease in general, of the alcoholic psychoses, and of the intemperate use of alcohol among all new admissions, it is of interest to compare these rates. The fifteen states from which data were received on the intemperate use of alcohol for the years 1921, 1922, 1925, and 1926 also provide data showing the total number of male and female cases of alcoholic insanity and similar figures for all new admissions. On the basis of the estimated male, female, and total population for this group of states for each of these years, the rates per 100,000 of general population may be summarized as follows:

RATES PER 100,000 OF POPULATION IN 15 STATES

	1921			*1922*			*1925*			*1926*		
	M	F	T	M	F	T	M	F	T	M	F	T
All new admissions..	53.4	44.2	48.9	56.5	44.6	50.7	53.7	44.0	48.9	52.8	43.0	48.0
Alcoholic psychoses..	2.8	0.4	1.6	3.4	0.4	2.0	4.3	0.7	2.5	4.4	0.8	2.6
Intemperate users of alcohol	10.8	1.5	6.2	11.8	1.7	6.8	11.4	1.9	6.8	11.5	1.9	6.8

[1] *Die Alcoholism in München,* by E. Kraepelin. München Med. Wchn. 1906, Z. iii, 737, cited by George W. Hall, M.D. in "Alcohol in Mental Disease." *Papers from the Conference on Mental Hygiene,* published by Illinois Society for Mental Hygiene, 1923.

TABLE 7. PERCENTAGE DISTRIBUTION BY AGE OF NEW CASES OF ALCOHOLIC INSANITY COMPARED WITH ALL NEW CASES ADMITTED TO STATE HOSPITALS FOR MENTAL DISEASE IN 19 STATES DURING 1926, 1925, AND 1922.

AGE	1926						1925						1922					
	All new cases			*New cases of alcoholic insanity*			*All new cases*			*New cases of alcoholic insanity*			*All new cases*			*New cases of alcoholic insanity*		
	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T
Under 15 years	0.5	0.5	0.5	0.1	0.0	0.1	0.6	0.5	0.6	0.0	0.0	0.0	0.9	0.9	0.9	0.0	0.0	0.0
15 to 19 years	4.5	4.1	4.3	0.2	0.5	0.2	4.6	4.5	4.6	0.0	0.5	0.1	4.0	5.5	4.6	0.1	0.8	0.2
20 to 24 years	8.4	7.6	8.1	1.9	2.4	2.0	9.0	7.9	8.5	1.9	1.1	1.8	10.5	9.0	9.9	1.8	0.8	1.
25 to 29 years	10.0	9.4	9.7	4.7	4.9	4.7	9.5	9.7	9.6	4.8	6.5	5.0	12.6	11.5	12.2	5.5	4.0	5.
30 to 34 years	10.2	10.7	10.4	11.1	11.7	11.2	10.7	10.2	10.4	11.1	13.5	11.4	11.3	12.6	11.8	11.1	9.7	11.0
35 to 39 years	11.1	11.3	11.2	17.1	18.0	17.2	12.2	11.8	12.0	17.8	16.8	17.7	11.0	11.5	11.2	18.1	18.6	18.1
40 to 44 years	10.4	9.7	10.1	18.2	15.0	17.8	10.4	9.9	10.2	19.9	18.9	19.8	9.3	11.8	10.3	17.6	21.8	18.0
45 to 49 years	8.9	9.6	9.2	15.0	17.5	15.3	9.1	9.6	9.3	15.9	15.1	15.7	8.3	9.5	8.8	14.9	24.2	15.9
50 to 54 years	7.4	7.6	7.5	11.7	11.2	11.6	7.3	7.7	7.5	13.3	10.8	13.0	6.6	7.1	6.8	13.9	8.9	13.4
55 to 59 years	6.2	5.8	6.0	8.5	8.7	8.6	5.7	5.8	5.7	7.6	8.1	7.7	4.9	4.7	4.8	7.8	4.0	7.4
60 to 64 years	5.7	5.5	5.6	6.4	4.4	6.1	5.5	5.4	5.5	4.6	4.9	4.6	5.2	3.5	4.5	5.3	4.0	5.1
65 to 69 years	5.5	5.1	5.3	3.7	2.9	3.6	5.1	4.8	4.9	1.7	2.2	1.8	4.9	3.0	4.1	2.6	2.4	2.6
70 years and over	10.6	12.5	11.5	0.7	1.9	0.9	9.5	11.3	10.3	0.8	1.1	0.8	9.9	8.4	9.3	0.8	0.8	0.8
Unascertained	0.6	0.6	0.6	0.7	0.9	0.7	0.8	0.9	0.9	0.6	0.5	0.6	0.6	1.0	0.8	0.5	0.0	0.5
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Very slight changes have taken place in the rates in these years.

Characteristics of Alcoholic Cases.—In addition to the general information presented above, the 19 states from which complete data were received for the years 1922, 1925, and 1926 returned schedules containing detailed information concerning age, education, environment, economic condition, and marital condition of all new admissions.[1]

Age Distribution.—The percentage distribution by age and sex for all new admissions and for new alcoholic cases is given in Table 7 (page 608). An examination of this distribution not only furnishes a comparison between the percentages of alcoholic and all other cases entering the hospitals at the ages given, but also further confirms the statement made by Pollock and Furbush in the study already referred to that "alcoholic insanity is principally a disorder of advanced middle life". It will be seen that out of every 100 patients with alcoholic psychoses, 76 entered between the ages of thirty and fifty-five in 1922, 78 in 1925, and 73 in 1926—that is, approximately three-fourths of the total number. Of all new admissions, only 49 entered between these ages in each of the years 1922 and 1925, and only 48 in 1926, or a little less than one-half of all new cases. This difference in age distribution is very clearly shown in Chart 4 (page 611), which, because of the large number of cases included and the general similarity of the curves for the three years, may be assumed to be indicative of the typical distribution.

Education.—Of each 100 patients with alcoholic mental disease admitted during the years 1922, 1925, and 1926, respectively, 9, 7, and 8 were illiterate; 22, 17, and 13 could read and write, but had not completed the fourth grade of common school; 56, 61, and 63 had received a common-school education; 6, 7, and 6 had completed high school; and 3, 2, and 2 had finished college. The education of 4, 6, and 7 was unascertained. The percentages by sexes are given in the following summary:

[1] Data for 1922 on education, environment, economic condition, and marital condition are from the study by Pollock and Furbush, above mentioned.

Degree of education	1922		1925		1926	
	Males	Females	Males	Females	Males	Females
Illiterate	9.1	12.2	7.4	3.8	7.5	9.2
Reads and writes	21.5	22.1	16.3	21.4	13.2	13.6
Common school	56.9	50.4	60.7	61.0	63.5	61.7
High school	6.2	6.1	6.5	6.6	6.0	6.3
College	2.9	1.5	2.5	1.7	2.6	0.5
Unascertained	3.4	7.6	6.6	5.5	7.2	8.7
Total	100.0	100.0	100.0	100.0	100.0	100.0

It may be noted that the degree of illiteracy among alcoholic patients is somewhat higher, except in the case of the females in 1925, than the percentages for the entire United States as given in the report of the Federal Census Bureau for 1920. These percentages were: males, 6.0; females, 5.9; and total population, 5.9.

Environment.—For the group of hospitals studied, it was found that of the alcoholic cases 80 per cent in 1922, 84 per cent in 1925, and 82 per cent in 1926 came from an urban environment—that is, from places having a population of 2,500 or over; and that 18 per cent in 1922, 14 per cent in 1925, and 15 per cent in 1926 were from a rural environment. The environment of 2.2 and 3 per cent in the respective years was unascertained. The following summary gives the percentages distribution for environment by sex:

Environment	1922		1925		1926	
	Males	Females	Males	Females	Males	Females
Urban	78.9	93.8	83.0	90.6	80.6	92.2
Rural	19.2	4.6	14.6	7.7	16.0	7.8
Unascertained	1.9	1.6	2.4	1.7	3.4	0.0
Total	100.0	100.0	100.0	100.0	100.0	100.0

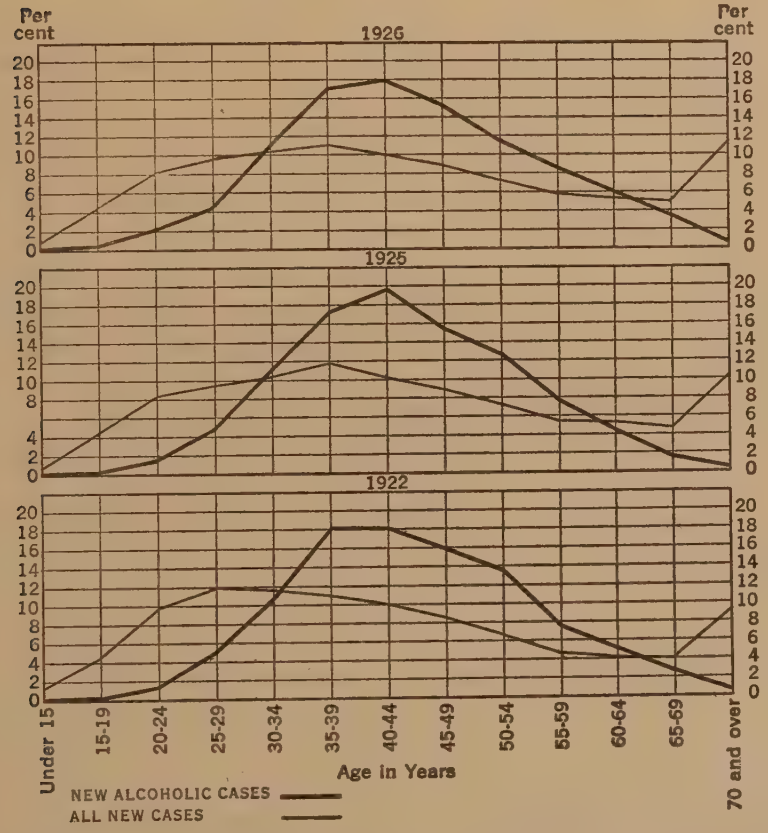
These figures again confirm the statement that a very high percentage of cases of alcoholic insanity come from an urban rather than a rural environment. This is particularly noteworthy in view of the fact that the United States Census Bureau gives the following percentages for urban and rural population in 1920: urban, 51.4; rural, 48.6.

Economic Condition.—The term "economic condition", as used in the reports of the various hospitals, refers to the patients' circumstances before the onset of the psychosis.

All patients are classified as follows: dependent—lacking in the necessities of life or receiving aid from public funds or persons outside the immediate family; marginal—living on daily earnings, but accumulating little or nothing, being on the margin between self-support and dependency; comfortable—having accumulated resources sufficient to maintain self and family for at least four months.

CHART 4

PERCENTAGE DISTRIBUTION OF NEW CASES OF ALCOHOLIC MENTAL DISEASE AND OF ALL NEW CASES ADMITTED TO THE HOSPITALS OF 19 STATES DURING 1922, 1925, AND 1926



For the year 1922, it was found that of each 100 new alcoholic admissions to 94 state hospitals, "21 were reported as dependent, 62 as marginal, and 13 as comfortable, while the economic condition of 4 was not determined". For 81 hospitals reporting in 1925 and 1926, the figures were:

dependent, 20 and 16; marginal, 65 and 69; comfortable, 11 each year; and the economic condition of 4 each year was unascertained. The percentages by sex for 1925 and 1926 are as follows:

Economic condition	*1925*		*1926*	
	Males	Females	Males	Females
Dependent	19.4	20.9	16.4	12.6
Marginal	64.5	67.0	67.6	76.2
Comfortable	10.9	10.4	11.0	10.7
Unascertained	5.2	1.7	5.0	0.5
Total	100.0	100.0	100.0	100.0

It is worthy of note that the marginal group comprises approximately 65 per cent of those suffering from alcoholic psychoses in 1925, and 70 per cent in 1926. The increase in 1926, with the corresponding decrease in the number comprising the dependent group, may possibly be accounted for by improvement in social and economic conditions.

Marital Condition.—The percentage distribution of marital condition of new cases of alcoholic insanity was found to be as follows for the years 1922, 1925, and 1926, respectively: single, 37, 33, and 33; married (including persons separated, but not divorced), 50, 53, and 53; widowed 9, 10, and 10; divorced 3, 3, and 4; and unascertained, 1 each year. The following summary shows the percentages for the two sexes:

Marital condition	*1922*		*1925*		*1926*	
	Males	Females	Males	Females	Males	Females
Single	39.7	11.3	36.0	8.3	36.7	9.2
Married	48.3	66.9	51.5	64.8	49.7	71.4
Widowed	8.1	17.7	8.3	22.5	9.1	12.1
Divorced	2.5	3.2	2.8	3.8	3.0	7.3
Unascertained	1.4	0.8	1.4	0.6	1.5	0.0
Total	100.0	100.0	100.0	100.0	100.0	100.0

From the summary it may be seen that the percentage of single men was more than three times that of single women in 1922 and approximately four times the percentage of single women in 1925 and 1926. The percentage of married women was considerably greater than that of married men each year, while the women also exceeded the men in the widowed and divorced groups. The excess of married over single

women was much greater than that of married over single men, there being six times as many married as single women in 1922 and approximately eight times as many in 1925 and 1926.

CONCLUSIONS

The data presented above warrant the following conclusions concerning alcoholic mental disease among the new admissions to the state hospitals for mental disease included in the group studied:

The number of new admissions to these hospitals increased from 1922 to 1925, but decreased slightly from 1925 to 1926. In spite of this latter decrease, however, the number in 1926 exceeds that in 1922.

The rate of new admissions per 100,000 of general population shows a slight decrease from 1922 to 1925 and again from 1925 to 1926.

The nine states that were "wet" before prohibition contributed more than 90 per cent of all cases of alcoholic insanity in 1922, 1925, and 1926.

The percentage of alcoholic cases among all new admissions to these hospitals for the years 1922, 1925, and 1926 shows a steady increase.

The percentage of alcoholic cases among all new admissions and readmissions to these hospitals in 1926 was less than one-half that of 1910, but slightly greater than that of 1922 or of 1925.

The rate of alcoholic insanity in twelve states in 1926 was slightly less than in 1919 or 1925.

Both the number and the per cent of intemperate users of alcohol among new admissions to the hospitals of 15 states show a small, but steady increase from 1921 to 1926.

Intemperate use of alcohol is present, at least as an accompanying factor, in many cases of mental disease comprising clinical groups other than the alcoholic psychoses.

The rate per 100,000 of general population in 15 states remained practically constant for new admissions and for intemperate users of alcohol, but increased slightly for alcoholic psychoses, during the years 1921, 1922, 1925, and 1926.

The following characteristics are noted among the cases of alcoholic insanity in the hospitals of 19 states:

Alcoholic insanity is primarily a disorder of advanced middle age, approximately 75 per cent of the cases entering between the ages of thirty and fifty-five years.

The degree of illiteracy abong alcoholic patients is somewhat higher than among the general population of the entire United States.

More than 80 per cent of alcoholic cases come from an urban, in contrast to a rural, environment.

Over 60 per cent of alcoholic cases have been in marginal circumstances, previous to commitment, and approximately 25 per cent have been in dependent circumstances.

With respect to marital condition, more than one-half of the patients suffering from alcoholic mental disease are married and more than one-third single. The number of single males greatly exceeds the single females, while the number of married and widowed females exceeds the number of males so classified.

"WOMAN, WHAT HAVE I TO DO WITH THEE?"

IF Mary, in those months before Christ's birth that shine
So tender, so sublime,
Across scarred, somber centuries,
Had planned with sweet insistence, saying, "These
Things he must surely do, my little son;
Always like this and this our race has won
Nobility",
Would he,
The child, have grown
To greater stature than his race had known?

But long before the first faint flutter stirred
Within her, Mary heard,
Authoritative, beautiful, a word;
Perhaps the wisdom of her spirit spoke,
A word that told
Her that the child that she would hold
Against her breast was royal. In deference Mary pressed
No brand of her designing on her son; she guessed
His purpose would fulfill itself and be
Clear to him as he strengthened for it; she
Let him, a youth, depart
From her, aloof, and in her heart,
Bereft and glad, pondered anew his saying . . . so alone
He sought and found—a throne.

JULIA WELD HUNTINGTON.

Norwich, Connecticut.

ABSTRACTS

THE VOLUNTARY HEALTH AGENCY. By Barry C. Smith. *American Medical Association Bulletin,* 24:144–49, May, 1929.

Harmonious coöperation between the voluntary health agency, the official health agency, and the private physician in carrying out a public-health program depends primarily upon mutual understanding and consideration. In its relations with the private physician, the voluntary health agency should recognize two facts: (1) that the physician is still largely occupied with the curative rather than the preventive and constructive aspects of medicine; and (2) that while he concedes the necessity of health agencies to handle such community problems as water supply, sewage disposal, and the like, he is still inclined to regard treatment of the individual as his particular province and to resent encroachment upon it. This attitude is likely to cause ill feeling in connection with such questions as immunization and the establishment of health centers for children—measures that involve treatment of the individual and yet are not the type of service that the individual is in the habit of seeking from his physician. In such matters the function of the voluntary health agency should be largely educative. It should educate the public to the necessity of the service, but should make it a practice to refer individuals to their own physicians for treatment, unless the physicians themselves decide that the service had better be performed by a health agency, voluntary or official. At the same time the physicians should be educated to make an active effort to develop their practice along preventive and constructive lines, as dentists are already doing.

In relation to the official health agency the function of the voluntary agency should be, briefly, to supplement, to educate, to demonstrate, to give moral and financial support, and at the psychological moment to disappear.

PSYCHOLOGICAL OBJECTIVES IN PHYSICAL EDUCATION. By J. R. Young. *American Physical Education Review,* 34:92–95, February, 1929.

This author points out some of the opportunities in physical education that he feels are being neglected at present because of a lack of coöperation between the departments of physical education and the academic departments in high schools and colleges, a situation in his opinion largely due to the persistence of a medieval concep-

tion of mind and body as two separate entities, of which the mind is by far the higher and more important. Influenced by this conception, the academic instructor is inclined to feel himself upon a higher plane than the teacher of physical training, with the result that a sharp line of demarcation is almost universally drawn between the two types of instruction and a certain antagonism has arisen between their respective exponents. This is unfortunate, since each needs what the other has to give.

The academic educator would do well to remember the value of games and sports as forms of intellectual, emotional, and volitional training. Rightly used, they are excellent agencies for developing initiative, resourcefulness, and independence and for building up that fine coördination between the nervous system and the muscles that leads to grace and ease and poise, qualities that are of economic and social as well as æsthetic value.

An important objective of physical education is the inculcation of ideals of health, physical efficiency, and emotional control. Emotional disorders are on the increase and it is significant that neuropathic individuals are usually introverts who have spent little time in athletics and sports. Activities of this kind are invaluable in preventing the development of high nervous tension. They are a natural safety valve for the emotions. And if, in developing the muscles of the body, constant emphasis is placed upon moral stamina, persistence in playing the game through, and endurance of hardship, the result will be a stiffening of the moral fiber of the youth which is, in the judgment of the author, one of the most important contributions of physical education. Competitive sports are also a splendid training in fair play, in coöperation, in the ability to maintain emotional balance in a crisis, in modesty in victory and self-control in defeat—in short, all the qualities that enter into the code of the "good sport". This code should be unremittingly emphasized throughout the whole course of physical education.

The attitude prevalent in our educational institutions to-day that the primary aim of organized athletics is to advertise the school or college has, in Mr. Young's judgment, had most unfortunate results. It places an exaggerated emphasis upon winning, which not only menaces good sportsmanship, but has led to such evils as the subsidizing of individuals of high athletic, but low intellectual, capacity. It tends also toward overspecialization, which results inevitably in a rather one-sided physical development.

The educator should look upon games and athletics as a wholesome and natural means of satisfying some of the strongest impulses of man's nature. First and foremost, they should serve as an out-

let to the play instinct or impulse. Under our present system of physical education, there is danger that this primary function of sports may be disregarded. In some cases they are undoubtedly regarded as a hard grind, to be undertaken, not for the joy of the activity, but for the rewards to be derived from it.

Another instinct for which sports offer a legitimate means of expression is that of self-display. This instinct is at its height in adolescence and should be provided for in any scheme of physical education. Opportunities for the display of athletic prowess, such as field days and other athletic events, and recognition of special attainment or successful accomplishment by such symbols as the letter on the sweater or the trophy cup, are invaluable for this purpose, always provided that they are not allowed to become the primary objective of the athletic program.

Pugnacity is a third deeply rooted instinct that finds a normal, healthy outlet in games and athletics, and that they can help to develop into a constructive element in the personality.

Workers in the field of physical education have long recognized the value of corrective gymnastic exercises for the body, but they have not been equally alert to the opportunities offered by games and sports for the correction of minor psychic abnormalities. Three types are mentioned as illustrations. There is, first, the over-modest, retiring individual of indifferent physique who suffers from a more or less definitely established inferiority complex. "Because of their general weakness and sense of inferiority, it is impossible to make athletes of more than a very few of them. They should, however, be encouraged to practice unremittingly some one game which is in fairly high prestige among adolescents. If they can be brought to the point where their proficiency surpasses the average for their group, this accomplishment becomes a tremendous asset in building up their morale and increasing their self-respect."

A second type is the very aggressive, egotistical individual who wants to play the game himself and will take long chances for the sake of greater personal glory. He must be taught to play as a member of the team and be taken out of the game every time he fails to do so, even though his removal may mean the loss of the game, and he should frequently be pitted against players who are better than he.

The third type for which the physical-education department can do a great deal is the dullard. Only too often the dullard gets little out of his academic work except the sense of failure. "If such individuals could be led to the attainment of excellence in some line of sport, it might be possible to bring many of them through

their limited school course with their self-respect still intact. Under present conditions many of this group find their school work a positive detriment. It robs them of two priceless heritages—self-respect and ambition."

ECONOMIC LOSS ON ACCOUNT OF HOSPITAL CASES OF MENTAL DISEASE AND ASSOCIATED PHYSICAL DISORDERS IN NEW YORK STATE, 1928. By Horatio M. Pollock. *The Psychiatric Quarterly,* 3:186–95, April, 1929.

The economic loss due to hospital cases of mental diseases is made up of two main items: (1) the cost of maintaining the patients in hospitals and (2) the loss of the patients' earnings. The first can be subdivided into (A) the cost of hospital care and treatment, including medical and nursing service, food, clothing, upkeep of buildings and grounds, and so forth; (B) the investment charge—that is, interest on the value of hospital plant and equipment and allowance for depreciation; and (C) the cost of general administration, which includes not only the administrative expenses of the department of mental disease, but the cost of the services performed for the department by other state departments and state officers.

For the fiscal year ending June 30, 1928, the per capita cost of care and treatment in the civil state hospitals of New York was $404.82 and in the hospitals for criminal insane $464.54. For the licensed institutions, Dr. Pollock estimates it at $2,000.

In computing the annual investment charge, he uses as a basis the cost of the new units at Kings Park, Creedmoor, and Rockland State Hospitals. These are the best figures available, since the last general appraisal of the land and buildings of the civil state hospitals was made as of January, 1912, when real-estate values were much lower than at present, and no new state hospital has been built and equipped in recent years. Computing from the cost of the new units, he places the present average outlay for plant and equipment at approximately $4,000 per patient for the state hospitals and $6,000 for the licensed hospitals. Using 5 per cent as a fair rate of interest and adding 2 per cent for depreciation, he estimates that the annual investment charge amounts to $280 per capita in the state hospitals and $420 in the licensed institutions.

The expenditures of the administrative offices of the department of mental disease in 1928 came to $6.71 per capita. The expenditures of other state departments and agencies for services to the state hospitals would probably increase this to $10 per capita.

On the basis of these figures, the maintenance cost of the 43,639 patients in the civil state hospitals in 1928 amounted to $30,358,909;

of the 1,719 patients in the hospitals for criminal insane, to $1,297,056; and of the 2,640 in licensed institutions, to $6,415,200—a total of $38,071,165.

In computing the loss of earnings due to the disability and premature death of patients with mental disease, Dr. Pollock uses the figures of Drs. Dublin and Lotka, of the Metropolitan Life Insurance Company, on the net economic value of a typical male wage earner at various ages. The economic value of the average woman is assumed to be half that of a man.

The proportion of this economic value that is lost when an individual develops mental disease and is admitted to a hospital, Dr. Pollock estimates separately for each clinical group, after a careful consideration of discharges, deaths, and duration of hospital life in each group. Thus, in cases of general paralysis, he estimates it at 75 per cent; in senile cases, at 95; in alcoholic cases, at 50; in the dementia-praecox group, at 75; and so forth.

To obtain the figures for 1928, he classifies according to sex and psychosis the first admissions to the state hospitals and the committed first admissions to the licensed institutions during that year, and determines by the Dublin-Lotka table what economic value each clinical group would represent if the individuals in it were normal. Multiplying this sum by the estimated percentage of loss due to the psychosis in question, he gets the amount of the loss for each group. The sum of the losses in the various groups comes to $67,542,629 for the males and to $24,364,841 for the females. To these losses must be added those of the voluntary and physician-certificate patients admitted to licensed institutions during 1928. As ages and psychoses are not reported in such cases, Dr. Pollock computes the losses of this group from the figures for the committed group, estimating them at $10,178,850 for the males and $3,444,768 for the females. This brings the total loss of future earnings of first admissions to $105,531,088, which, added to the $38,071,165 spent for maintenance, gives a grand total of $143,602,253 as the loss due to hospital cases of mental disease in New York State in 1928.

Of interest also are the figures for the losses due to some of the individual psychoses. Thus, the loss on account of general paralysis is estimated at $15,757,008, and on account of syphilis at $813,588, making a total of $16,570,596 for the syphilitic group. Cases of alcoholism are responsible for a loss of $6,561,973, while the loss from dementia praecox amounts to the enormous sum of $61,907,331.

BOOK REVIEWS

COMING OF AGE IN SAMOA; A PSYCHOLOGICAL STUDY OF PRIMITIVE YOUTH FOR WESTERN CIVILIZATION. By Margaret Mead. New York: William Morrow and Company, 1928. 297 p.

This book was given to me by an old rake in evident disappointment over the fact that it had not turned out to be a salacious novel, as he had been led to believe from the lurid paper cover. This cover portrays a Samoan youth chasing a girl in a grass skirt "under the palm trees". One does not have to read very far to learn that "under the palm trees" is the accepted rendezvous for clandestine lovers. In addition, there appears in red print George A. Dorsey's comment: "I wonder if we shall ever be as sensible about sex as the Samoans are." Whether or not these are designs aimed at increasing popular consumption, the book is a valuable sociological contribution. It is the kind of source material upon which such monumental works as Briffault's *The Mothers* are built. No doubt its sensational get-up is the publisher's, rather than the author's, method of increasing popular sales of the volume.

The data upon which the book is based were gathered by the author during a period of residence among the Samoan natives—first-hand information, therefore, of the most authentic kind. She set out with an express purpose in view. Aware of the storm and stress of the adolescent period in America, Miss Mead wondered whether the symptoms of unrest during this period are inevitable concomitants of the physiological changes or whether they are due to the environment with which the adolescent is confronted and in which he matures. Are "these difficulties due to being adolescent or to being adolescent in America"? It is obviously impossible to apply the behaviorist's experimental method of controlling the variables. Miss Mead, therefore, turned to the anthropological method, really a comparative sociological study, and sought a civilization in which the environment is radically different. Especially are the attitudes toward sex in that society fundamentally different from our own; and since much of adolescent unrest is centered about sex, it would seem that a comparison of the influence of these differing attitudes upon the adolescent is particularly illuminating and valid. Miss Mead finds a complete absence in the Samoan girl passing through puberty and adolescence of any of the signs and symptoms of stress and maladjustment that one frequently encounters in American youth. "Adolescence represented no period of crisis or stress, but was instead an orderly

development of a set of slowly maturing interests and activities. The girls' minds were perplexed by no conflicts, troubled by no philosophical queries, beset by no remote ambitions. To live as a girl with many lovers as long as possible and then to marry in one's own village, near one's own relatives, and to have many children, these were uniform and satisfying ambitions."

The Samoan child is from the earliest years exposed to sex knowledge; she witnesses intercourse, abortions, and births. Sex thus loses its mystery, gives rise to no guilty knowledge, and is relegated to the category of physiological functions; the chief restrictive impositions are those of ordinary decency—*e.g.*, one would not defecate or engage in sexual intercourse in the public square — plus, of course, the taboo relating to one's own family. Furthermore, the boy, on reaching puberty, is taught all the details of sex and the art of love-making. "The fact that educating one sex in detail and merely fortifying the other sex with enough knowledge and familiarity with sex to prevent shock produces normal sex adjustments is due to the free experimentation which is permitted and the rarity with which both lovers are amateurs." "Familiarity with sex, and the recognition of a need of a technique to deal with sex as an art, have produced a scheme of personal relations in which there are no neurotic pictures, no frigidity, no impotence, except as the temporary result of severe illness, and the capacity for intercourse only once in a night is counted as senility." "Marriage, on the other hand, is regarded as a social and economic arrangement in which relative wealth, rank, and skill of husband and wife, all must be taken into consideration. There are many marriages in which both individuals, especially if they are over thirty, are completely faithful. But this must be attributed to the ease of sexual adjustment on the one hand, and to the ascendency of other interests, social organization for the men, children for the women, over sex interests, rather than to a passionate fixation upon the partner in marriage. As the Samoans lack the inhibitions and the intricate specialization of sex feeling which make marriage of convenience unsatisfactory, it is possible to bulwark marital happiness with other props than temporary passionate devotion. Suitability and expediency become the deciding factors."

But there are other differences in attitudes and customs between Samoan society and our own that have their effect upon adolescence and play as great, if not a greater, rôle in effecting an easy adolescent adjustment in Samoa. There is the general casualness and lack of deep feeling with which the Samoans face all the problems of life. "For Samoa is a place where no one plays for very high stakes, no one pays very heavy prices, no one suffers for his convictions, or

fights to the death for special ends. Disagreements between parent and child are settled by the child's moving across the street, between a man and his village by the man's removal to the next village, between a husband and his wife's seducer by a few fine mats." Of special interest to the behaviorist, the psychoanalyst, and the child-guidance worker is the difference in social and psychological environment of the first few years—family relationships and conflicts. "The organization of a Samoan household eliminates at one stroke many of the special situations which are believed to be productive of undesirable emotional sets. The youngest, the oldest, and the only child hardly ever occur because of the large number of children in a household, all of whom receive the same treatment. Few children are weighted down with responsibility or rendered domineering and overbearing as eldest children so often are, or isolated and condemned to the society of adults and robbed of the socializing effect of contact with other children, as only children so often are. No child is petted and spoiled until its view of its own deserts is hopelessly distorted, as is so often the fate of the youngest child." "The close relationship between parent and child, that submission to the parent or defiance of the parent which may become the dominating pattern of a lifetime, is not found in Samoa." The diffusion of feeling and affection possible in the loosely organized Samoan family is in striking contrast to the specialization and fixation of emotion in our own small, ingrown biological family. There is lacking the tendency to base conduct on affection ("Please be good to mother" and "Go to church for father's sake") rather than on a broader tribal ethics.

Still other differences in social structure and social attitudes that have their influence on the pre-adolescent are the presence of many strongly held and contradictory points of view and the enormous influence of individuals in the lives of our children; the Samoans' low level of appreciation of personality differences and poverty of conception of personal relations; their "general educational concept, which disapproves of precocity and coddles the slow, the laggard, the inept"; their scheme of introducing very early into the life of the child definite tasks graded to their strength and intelligence, but having a meaning in the structure of the whole society, their child's play having no relationship to adult work, as in our own scheme; the matter of choices, the Samoan adolescent not being faced by the number of nor the pressure to make, important choices, such as those involved in religion, morality, a career, political preferences, and what not.

Miss Mead wisely refrains from giving rash solutions of our

adolescent problems on the basis of these comparisons and contrasts. "Many points are useful only in throwing a spotlight upon our own solutions, while in others it is possible to find suggestions for change. . . . Our attitude towards our own solutions must be greatly broadened and deepened by a consideration of the way in which other peoples have met the same problems."

In the final chapter, *Education for Choice,* the author realizes that adolescence is not necessarily a time of stress and strain, but that cultural conditions make it so; that these conditions are the flesh and bone of our society and no more subject to straightforward manipulation than is the language we speak. Some slight change in our attitude toward sex might be possible, *e.g.,* the sex conduct of young people might be conceived of as experimentation instead of as rebellion; "but when there is added to the pitfalls of experiment the suspicion that the experiment is wrong and the need for secrecy, lying, and fear, the strain is so great that frequent downfall is inevitable". It is in the matter of choices that our greatest hope lies. "We must turn all of our educational efforts to training our children for the choices which will confront them. Education, in the home even more than at school, instead of being a special pleading for one régime, a desperate attempt to form one particular habit of mind which will withstand all outside influences, must be a preparation for those very influences. Children must be taught how to think, not what to think. Unhampered by prejudices, unvexed by too early conditioning to any one standard, they must come clear-eyed to the choices which lie before them."

In the appendix the author tabulates her data objectively and gives a brief mental-hygiene survey of the villages in which she worked. This tends to show the relative infrequency of adult neuroses and psychoses.

The book is extremely readable and the style excellent. It is a remarkable study in causation, from which the reader may draw his own conclusions, remembering always that civilization is purchased at a price. This price may be too high in some instances, but that is the inevitable result of that aggressive attack upon the problems of reality which has brought us our civilization and has lifted us above savagery. Thus, the inhibition and postponement of sexual expression has raised sex to a higher plane, has given us the beauty of romantic love, and has turned a vast amount of libidinal energy into ego drive with a resulting superiority of achievement.

ARTHUR R. TIMME.

Child Guidance Clinic, Los Angeles and Pasadena.

CHILDREN'S BEHAVIOR AND TEACHERS' ATTITUDES. By E. K. Wickman. New York: The Commonwealth Fund Division of Publications, 1928. 247 p.

It is a maxim known to all adults that "good" children are those who do not bother their elders. Children who refuse to adopt this maxim are known as "problem" children. What psychologists who refuse to adopt it are known as is an interesting field for speculation, but Mr. Wickman has apparently been willing to run the risk. In pursuit of the fascinating possibility that there might be problem teachers as well as problem children, and that there might, indeed, be some co-relation between the two, he has proceeded to an investigation and classification of the forms of pupil behavior which teachers seem to regard as generally and persistently troublesome. Then, having arranged these troublesome acts in the order of frequency with which the teachers complained of them, he submitted the same list of misdeeds to a group of clinical psychologists to be arranged in the order of their importance for the psychological health of the child. He hardly needs to set forth his tabulations to point the inevitable moral.

Grouping the almost endless list of specific misdeeds into general classifications, Mr. Wickman is able to summarize the attitudes of teachers as follows: most important and serious in their eyes are immoralities and dishonesties and transgressions against authority; next in importance and seriousness to these come violations of orderliness in class and lack of application to school work; next to these, in turn, come extravagant, aggressive personality and behavior traits; and last and least important are the withdrawing, recessive personality and behavior traits. More obvious evidence of the widespread persistence of the maxim mentioned in the preceding paragraph it would be difficult to find. Indeed so completely do these findings mirror the attitudes, not only of teachers, but, as Mr. Wickman points out, of parents and adults generally as well, that further comment is almost superfluous.

The psychologists have a different story to tell. For them the most serious and important forms of "misbehavior" are these same withdrawing, recessive personality traits which bothered the teachers least. Next to these in importance come dishonesties, cruelty, temper tantrums, and truancy. Next to these, in turn, are the immoralities, violations of school requirements, and extravagant behavior traits. Last and least important are the teachers' favorite shibboleths, transgressions against authority and violations of orderliness in class.

Mr. Wickman comments briefly on this state of affairs, pointing out that the teachers' attitudes in such cases are in effect defense

mechanisms for the protection of the personality and authority of the adult. When the child breaks a rule, whether in some matter of general moral conduct or in the matter of a specific school requirement, his defiance amounts to an attack on the personality of the adult who promulgates and defends the rule. As a result, the teacher tends to respond, as most human beings do to an attack, by a blind blow (not necessarily literally, of course) in return. The psychologist, less concerned with the preservation of the rule, sees the child's "attack" as less serious, as indeed almost a sign of mental health, while he regards the withdrawing and recessive behavior as possibly the beginning of serious maladjustment for the child.

Mr. Wickman's suggestion is that teachers be more adequately informed concerning what constitutes "normal" behavior and concerning the origins of children's difficulties in adjustment. He points out that many adults have themselves failed to adjust to these same problems and cannot, under such circumstances, be very successful teachers of children. A reëducation in teachers' attitudes would, he thinks, improve the teacher-pupil relationship.

Of the general soundness of all this there can hardly be any question. One point remains that Mr. Wickman has not, perhaps, quite appreciated. Our schools are still conducted, tacitly though not admittedly, on the principle made immortal by Mr. Dooley: "It doesn't matter what you teach a boy, Hennessy, so long as he doesn't like it." Of this situation the teacher is likely to be quite as much a victim as the pupil. Many times when the child and the rules come into conflict, the only solution is a new kind of school, and new kinds of schools do not materialize like rabbits out of a magician's hat. That the teacher should ever find it necessary to sacrifice the pupil to the rule is deplorable beyond all expressing, but some of the responsibility must rest on the administration and on the community. The reëducation in attitudes of which Mr. Wickman speaks is vitally needed, but teachers, as Mr. Wickman would probably readily admit, are not the only ones who need it.

Northwestern University. T. Livingston Scholtz.

Physique and Character: An Investigation of the Nature of Constitution and of the Theory of Temperament. By E. Kretschmer, M.D. Translated from the second revised and enlarged edition by W. J. H. Sprott. New York: Harcourt, Brace, and Company, 1925. 266 p.

There would be little occasion to notice this book in its second edition if it were not to point out the fact that there have been

many additions to the literature in the last few years—studies to which there is scant reference in Kretschmer's book, many of them having been made since he revised his German edition in 1922.

It should be known to those interested in this field that a very competent comparative review of the whole subject of biological types, as expounded by Kretschmer, Spranger, Von Klages, Ewald, and several others, was published in 1926 by H. Hoffman, under the title of *Das Problem Des Charakteraufbaus.* This work deals particularly with the relationship of body type to personality. A still more detailed comparative study of constitutional types, by F. Weidenreich, was published in 1927 under the title *Rasse und Koerperbau.* The findings of the German, French, and Italian schools are here presented in most interesting form from the standpoint of the relation of bodily structure to racial characteristics—certainly a highly important matter. A mere survey of the literature in bibliographic form occupies five large, closely set pages, which give to the student an indication of the extent of the research on the subject of body structure. Still more recently, we are fortunate enough to have the very notable work of Nicola Pende presented to us in the English translation by Naccarati (1928) under the title of *Constitutional Inadequacies; An Introduction to the Study of Abnormal Constitutions.* This fascinating volume, by the famous professor of clinical medicine and director of the Biotypological Institute of Genoa, shows, as no other work does, the many constitutional problems, other than those of anthropometrically determinable structure, that have to do with the better understanding of the nature of man, even from a psychological standpoint.

From all this it is evident that the last word is very far from having been said upon the relationship of body structure and function to personality or to mental abnormality. Kretschmer's studies, to come back to him, must be viewed in the light of Viola's work, which dealt particularly with the "total constitution". Then the whole matter must be considered from the standpoint of the comparative theories of body structure as presented by Weidenreich. Finally, we may well come to the localized body or organic characteristics, the "partial constitutions" that Pende deals with. The whole matter thus becomes tremendously complicated.

Kretschmer gave a great impetus to research in this field through his interesting presentation of the subject. He stood midway between the earlier students of the constitutional types, who evidently had little conception that there was anything very practical to offer in the way of elucidation of personality types, and those who have taken a much more critical view and have seen greater complexities.

But the whole subject remains immensely fascinating, with indications of permanent values for the psychiatrist and the psychologist appearing here and there. It is clear, however, that massive generalizations are not likely to prove of great value.

WILLIAM HEALY.

Judge Baker Foundation, Boston.

CHILDREN IN THE NURSERY SCHOOL. By Harriet M. Johnson. New York: The John Day Company, 1928. 325 p.

Increasing interest in the nursery school makes Miss Johnson's book a very timely one. It is also exceedingly honest; it starts with a frank acceptance of the fact that we are still learning about the pre-school child and that many questions of nursery-school routine are still open to discussion. The following passage is typical of the balanced and objective point of view that pervades Miss Johnson's work:

"Upon the subject of training in bladder control we hold a point of view which is at variance with that of the usual parent or physician and perhaps with many persons who have small children under their charge. I believe that too much emphasis has been laid upon the importance of acquiring early control of urination and other habits of self-help. Parents begin correctly when they attempt to establish regular habits in urination and the evacuation of the bowels when the baby is a few months old. They make no demand upon the baby, but assume the responsibility of placing him in the correct position at regular intervals. By the time he can creep, however, the method is likely to be changed. The child is exhorted to 'tell mother'. Often he is reproved or even punished for involuntary voiding of urine, and from that time on till control is physiologically established, the subject is one of exaggerated importance in the minds of the parents, of much discussion when children are being talked about and above all when mother and child come together. Various attacks are made upon it, a usual one being the effort to create in the child an aversion for soiled clothing and an association of disgust with the sight of urine and feces.

"We have raised the question whether much of the storm and stress experienced in the adolescent and adult years over the problem of sex relationship and an adjustment to sex life are not tied up with an early misunderstanding regarding the processes of elimination and those of sex. However that may be, it is one thing which we have in mind in putting a minimum of emphasis upon the habits concerned with elimination, at the same time endeavoring to get each child's 'rhythm'—*i.e.*, the periods between voiding—so that he can be taken

to the toilet and thus remain dry. We are still raising interrogations as to the importance of even this amount of supervision, that is, if being kept dry has any effect upon the establishment of bladder control." (Pages 29–30.)

This is only one example of Miss Johnson's attitude toward child-training problems in the nursery school, but it illustrates her philosophy. The whole aim of nursery-school training is not to impose conventions and routine decided from without, but to provide a favorable environment for the natural development of the child. "Growth is progress toward maturity. It is, however, a continual and gradual process, complete at each stage, or perhaps I should say capable of functioning at each stage. The duty of the educator is to see that the capacities of each stage are fully realized, not that the stages succeed each other as rapidly as possible." (Page 9.) This point of view carries us somewhat away from the emphasis on habit training which has too often been conceived as the primary function of the nursery school. "We cannot build up an entire educational system upon the cultivation of habits, important as they are . . . the habits which a person acquires are of less significance than the use he makes of them." (Page 17.)

How does this philosophy work out in actual practice? There is recognition of the differences between those things that are essential to the child's health and those that are demanded by adult social standards. There is much time spent upon securing good food and sleep habits, because these are necessary for physical well-being. On the other hand, children under three years of age are not expected to dress and undress themselves without adult assistance; nor is any stress placed upon the cultivation of pretty manners or the use of such expressions as "please" and "thank you", which at the nursery-school age can be only mechanical responses without any real meaning to the child. Even in methods of establishing the very necessary habits of proper eating and sleeping, there is much variety of procedure based on an understanding of individual differences. For instance, adult aid may be supplied to a child whose muscular coördination is not sufficiently well developed to insure successful self-feeding, but denied to a child who is simply trying to prolong the period of infantile dependency.

Thus far we have indicated only the kinds of problem that are discussed in the first two chapters of Miss Johnson's book. The other chapters are equally refreshing and stimulating. They treat of the following subjects: the schedule and the rules; the physical environment; the social environment; language and rhythm; record keeping

in the nursery school. Altogether this may be regarded as an excellent handbook of the best nursery-school technique.

PHYLLIS BLANCHARD.

Philadelphia Child Guidance Clinic.

THE MORAL SELF; AN INTRODUCTION TO THE SCIENCE OF ETHICS. By Charles L. Sherman. New York: Ginn and Company, 1927. 365 p.

In his preface the author outlines his purpose as follows: "The present volume attempts to present the problems of the moral self in as untechnical a manner as possible. Likewise is the attempt made to trace the genesis of the moral self, in terms of its essential features, from biological foundations to metaphysical implications."

In the first chapter he gives a general orientation for the presentation of the subject from his point of view. He outlines, as forms of mental organization, the following: (1) emotional, (2) logical, (3) philosophical, and (4) moral. He holds the mind to be consistent along the lines of these four categories, the first three being but a preliminary to the fourth, "which is the consistency of the moral self". He states that the moral self is "a qualitative attitude which is always turned in the direction of the reciprocal interests of society and of self". He proposes four requisites: (1) ideals, (2) feelings, (3) tendencies, and (4) organization. He believes that it is necessary in early life to have a fairly constant moral environment in order to develop the moral self to its highest possibility. He also discusses types of humanity on the basis of attitude toward the universe, under the headings of the optimist and the pessimist, the introvert and the extrovert. He holds that such extreme views constitute a prejudice which, if adopted in early life, may be sufficient to become the background of a permanent philosophy of life. "It is likely that prejudice is the foundation for most moral natures even of the very highest order—but beyond the early states of one's moral experience it should have no further rôle to play."

Self-observation is considered important for self-evaluation and the author would make self-criticism a criterion of intelligence. But he would not have the individual introspective too early in life. "It is much better to be a normal human being with normal objective interests than to become a psychologist." Sensation, purposes, and associations are advanced as the sources of selfhood, and the higher experiences of ideals and purposes are considered as formative. Throughout this first chapter he dwells a great deal upon unity of the individual. "Unity has been our most important thesis—a moral unity as well as a psychological unity."

In the second chapter he deals with psychological tendencies in relation to the self. He considers three stages in the development of moral activity: (1) the unconscious development of interests and tendencies to action; (2) the conscious and purposeful development of interests and tendencies; (3) the abnormal development of interests and tendencies. "It is possible to summarize three theses in a nutshell: The aim of education is the proper directing of human tendencies; the lack of education is the failure to develop one's tendencies; and the abnormal self, if we may use the term self, results from the misdirecting of human tendencies." The thesis is then advanced that similar mental states tend to succeed one another, and this sequence takes place along three lines—the emotional, the habitual, and the logical. These are considered in special relationship to morals. He holds also that mental processes tend to attain an ideal status, but that this tendency is an acquired one. "When this stage has been reached (and ordinarily it never is reached) the moral self advances by leaps and bounds." Stating that moral values are not competitive and that the moral self is built up by self-sacrifice, he passes to a discussion of art to illustrate his point.

In Chapter III the biological foundations of the moral self are considered. Individual variations in intellectual and moral capacity and the application of these variations in education and industry are discussed at length. A discussion of racial variation follows. The author states: "The idea that nations differ in innate capacities is not at all novel in the history of social thought." (This doctrine of differences in racial capacity is receiving very severe criticism to-day. While it is probable that quantitatively the racial capacities are approximately equal, it is also probable that there are fundamental qualitative differences.) He states further that races differ less in moral integrity than in range of intellect, but that "racial morality is subject to wide variation. Two distinct races may possess equal degrees of moral integrity, but such integrity will manifest itself in a myriad of forms."

Instincts are next discussed as possible roots of the moral self. The author reaches the deduction that "in the fields of education and morals the instincts seem to provide the necessary background for intellectual and moral motivation. This does not imply that instincts are motives in themselves; it means that motives arise from such tendencies." He holds that there is a unity of the physical, the mental, and the moral capacities, all three being more or less interdependent. He discusses next ambivalence of interests and emotions in their relation to regression and the development of anti-social tendencies. The chapter closes with a discussion of habit and its bearing on moral behavior.

Chapter IV opens with a discussion of the forms of self-organization. Five principles are advanced: (1) the mechanical, (2) the logical, (3) the organic, (4) the purposeful, and (5) the self-conscious. Each of these the author discusses in their relation to morals. The mechanized character he believes could never attain a truly moral status, as it simply mirrors the society surrounding it. The logically and the organically synthesized personalities are considered to be early stages of moral synthesis. The purposeful organization of the self holds potentialities for the subordination of minor life interests and the development of a truly virtuous life. The self-conscious organization permits of recognition of one's self as a responsible and free moral agent.

The fifth chapter deals further with psychological concepts. The moral self is analyzed in terms of feeling, cognition, and will. Feeling is analyzed under the headings of feeling, motivation, and sentiment. One is cautioned against the tendency of persistent affect to narrow thought. The author considers that feelings give rise to motives and therefore essentially underlie moral behavior. "A really dynamic and constructive character can be founded only on motives that are fully conscious and definite." He draws a distinction between purpose and motive. The motives and feelings in turn, when properly organized, give rise to sentiments, which he considers to be the funding agencies of the moral self when they are attached to justice, integrity, honor, and so forth. He considers the moral energy arising from the sentiment to be directly proportionate to the normal maturity of the sentiment itself. The moral sentiments are held to give rise to conative tendencies. "The four stages of mental conation are as follows: first, the instinctive and spontaneous stage; secondly, the conscious interest in the attainment of some object or the accomplishment of an ordinary task of life; thirdly, the development of one or more specific virtues, or even the desire to live a virtuous life; fourthly, the desire and satisfaction that supervene upon the unfolding and expansion of the moral self."

Under cognition, he analyzes first environmental factors and their effects early and late in life, psychological determiners, sources of aversion and desires, and sources of minor morals. Moral percepts, concepts, and ideation are then discussed. He considers the concepts the controlling mechanism for the impulses. This brings him to a discussion of the will. "The first function of the will does not consist in the repression of desires and impulses; neither is it wise to allow the impulsive life free reign; but the primary function of the will is the proper guidance of the affective and conative tendencies."

Enough has been given so far to illustrate the general plan of attack. In the next two chapters he considers morals in relation to

society—"socializing the self"—and in relation to social forces and social institutions. In the eighth chapter he discusses the self in relation to moral judgment. Defining the meaning of moral judgment, he states that "any statement or assertion which predicates a moral quality or act is an example of moral judgment". The content of moral judgment would have the following indices: the historical, the social, the educational, and the formal virtues. The first would deal with man's present moral status; the second with the moral status of the community; the third with formal normal education; and the fourth with the abstractions of the formal virtues. The origin of this content he finds in heredity, environment, and the will. As to the sanctions of moral judgment, he quotes Bentham and Spencer.

In Chapter IX specific objects, agents, standards, and values are considered. Chapter X deals with the moral self in its relations to the personality. The stages in the development of moral personality are outlined. "The first stage is that stage in which the personality takes root and buds with the utmost secrecy . . .; the second stage of its growth, which we characterize as the selective choosing, though relatively unstable, is valued in terms of individual choice and social approbation . . . It is only as we pass from adolescence to spiritual maturity that we find real qualitative changes in the chosen personality. The instability of adolescence gradually becomes the stability of adulthood, as cosmic approval takes the place of social approval. Character is no longer fragile and many-sided, but permanent and enduring. Man's moral reserves have been tapped, and human personality, the highest gift of conscious choice, has assumed its rightful heritage."

The reviewer scarcely knows how to evaluate this work. He was seldom in rapport with the author at any stage in the development of the thesis. Moreover, long-continued perusal of scientific articles in which the objective data of actuality are presented prior to the drawing of conclusions spoils for one any work like the present, which contains innumerable assertions unsupported by any factual evidence. The primary thesis that the personality may be integrated on a moral basis is not demonstrated, in my opinion, by this work. To pick out at random a few examples of debatable assertions: "Intellectual, moral, and spiritual precocity has never been conducive to the highest flower of the moral self." (Page 83.) "It is true that such a departure [of a highly moral man from the paths of integrity] from virtue may never be adequately accounted for, but if an accurate analysis of the delinquent's motives could be had, it would be found that there had been a substitution of immoral for

moral motives." (Pages 95–96.) One should rather look first for organic brain disease. Surely the psychiatrist has a different point of view. "The child who is not required, during the early years of life, to perform definite, set tasks over long periods of time, even though such tasks be mechanical in nature, will probably never develop a genuine sense of economic responsibility. Such a conclusion as this is more than mere theory; it is an established, concrete fact." (Page 121.) "When we tell the truth or are virtuous simply because cold intellect requires it, virtue has already lost some of its reward." (Page 167.) On page 237, a paragraph is devoted to the statement that change in belief is dangerous. I should hold the converse to be the case. On page 239, we find: "Too much moral and religious brooding is a real actuating agency for what is sometimes known as psychasthenia." Here he comes into my own field, where the assertion is safe that such moral and religious brooding is a symptom and not a cause.

Almost every page contains some example of this kind. What the book may be worth in the field of morals is beyond my capacity to judge, but from the standpoint of the problems of practical living as we encounter them in psychiatry, it is of little value. It is not permissible to write a counter thesis in a review, but surely the condemnation or approval implied in moral judgments as here conceived would be a handicap in understanding life as we see it objectively and in reality. From the mental-hygiene point of view the attitude toward child guidance alone would be sufficient to condemn the book. "The only true maxim would be never to permit the child to look upon the bad. The mere percept may be more powerful in the establishment of associations in its favor than any number of moral maxims to the contrary." (Page 157.) We are familiar enough with the results of careful shelter from the realities in early life. What happens to the unprepared adolescent when he encounters reality?

Colorado Psychopathic Hospital. LAWRENCE F. WOOLLEY.

MODERN YOUTH AND MARRIAGE. By Henry Neumann. New York: D. Appleton and Company, 1928. 148 p.

In this book Dr. Neumann has undertaken to answer the advocates of "companionate marriage". He meets "with frankness and fairness" the challenge of their claims that youth refuses to be "chained" by marriage; that, "capable of just as much loyalty as ever before, they want to be, as they say, unforced"; that permanence in marriage is no longer regarded as essential. He calls this "the new problem raised by this age of freedom and revolt".

The titles of his six chapters indicate the development of his argument: *The Revolt, Why Monogamy? Romantic Illusions, What Naturalism Overlooks, Plea for Privacy,* and *Preparations.*

The chief themes in Dr. Neumann's discussion are youth's desire for and interpretation of freedom and responsibility. He does not believe that man can live unto himself alone.

Youth seems to have pushed aside romance and duty as illusions. It wants nothing less than facts—truth, naked and unafraid, though "there are new vagaries as well as new truths. Their newness does not make them true." Human beings cling to illusions, however, and youth has fantastically picked out freedom, the so-called freedom of having your way, doing what you please, when you please, and as you please, not comprehending that such freedom is the greatest illusion of all. "It is hard to see", he says, "how people can be human and free on any other terms than those of self-control." And, again, "All freedom worth having is won by accepting life's limitations understandingly."

The heart of the problem is the question, "What shall freedom mean?" We are not free merely because we reach the age when we can no longer be coerced. "The more one is at liberty to go his own way, the greater is the responsibility to prove that he can go sensibly. Every lifting of outward restrictions requires all the more control from within." "The real problem of liberty begins only at the point where external pressure has been lifted." "The fundamental question is not at all whether one is going to be bound or be free. It is the more practical question by what we are to be bound—by the undisciplined, capricious part of us, or by the good sense which marks the higher life."

He sets forth the difficulties besetting marriage, both personal and economic, and some of the many reasons why people marry.

He attacks companionate marriage as an attempt "to build up a so-called new ethics out of people's weakness. It offends because it looks ultimately in the direction of sanctioning indulgence rather than promoting control." He repudiates as false the idea that "the best which people can get out of their relations with each other is pleasure".

That youth cannot be coerced, but must be persuaded, and that the way to persuade is "that of making the better way appeal on its merits as the better", Dr. Neumann is convinced. To him there is no doubt as to the better way. He puts clearly before us his reasons for his belief in the possibilities of successful marriage, which he calls "a priceless training". He believes in self-discipline, in character, in

the joy of shouldering responsibility. "It will be a pitifully flabby world where responsibility is put anywhere but first."

He states, "What these pages desire to stress, therefore, is rather the crying need for ethical preparation before marriage and the sound education required, and permanently so, ever after." He believes that preparation for marriage begins in babyhood.

Dr. Neumann is both an idealist and an optimist. "Youth has begun to think for itself without fear." His style is terse and temptingly quotable. He has the gift of humor. His arguments are not new, but they are well marshalled and his book is well worth reading more than once.

What new solutions the coming generations will find to these old problems we cannot know. The older generations warn, the younger dance and yawn, and the world's still at its dawn.

EDITH N. BURLEIGH.

Child Guidance Clinic,
Los Angeles and Pasadena.

THE EDUCATION OF THE MODERN BOY. By Alfred E. Stearns, Samuel S. Drury, Endicott Peabody, R. Heber Howe, W. Q. W. Field, and William G. Thayer. Boston: Houghton Mifflin Company, 1928. 271 p.

A more specific title for this volume would be *The Education of the Modern Boy During His Boarding-school Years.* The subject matter deals almost exclusively with the boy between the years of twelve and eighteen, and concerns the boy in the private preparatory school. Very little is said about his education prior to his twelfth year, and even the chapter on home influence, which is one of the best in the book, does not take into account those earlier formative years which have so much to do with what the boy really is when he enters boarding school. Dr. Gesell has said that education begins at birth, and psychologists and psychiatrists, as well as educators, are realizing more and more that the first six years of life are of tremendous importance in education, providing education is considered as the development of proper habits of thought, emotional responses, and behavior, and not so much as the memorizing of Latin and history dates. In spite of the statement in the last chapter that "the vital period in education is that covered by the years from twelve to eighteen", it seems that the title should be more specific, so that it will not be misleading.

It is rather interesting to note that the chapter on athletic influence is the longest in the book, while the briefest chapter is that on academic influence. Perhaps athletic coaches and others concerned

would say that this proportion is as it should be, and it does seem that the section devoted to athletic influence contains many more practical suggestions on the subject of character building than are to be found under any of the other titles, with the possible exception of Stearns's contribution on home influence. The future trend of the private school away from the "prep school" idea and toward the goal of making the most of the inherent freedom of the private school seems to be one of the most important ideas formulated in the book.

The introduction warns us that "the voice of the headmaster is authoritatively heard", but we could not ask for better authority than is heard in this book. The articles collected here should meet a need that parents of the adolescent boy have felt and recognized for some time. If other educators dealing with boys in other years and situations, from the nursery school through college, would compile a similar work, and if the psychologist and psychiatrist would add their contributions, we should have a fairly comprehensive view of the education of the modern boy. Needless to say, the education of the modern girl should be given the same consideration. Let us hope that the example of these men will be followed by others concerned with this important problem.

Lloyd H. Thompson.

Yale University.

Introduction to Social Statistics. By Clarence G. Dittmer. Chicago: A. W. Shaw Company, 1926. 167 p.

The key to this work may be found in the preface, where the author states that his readers are expected to be "sociology students . . . few of whom will ever become professional statisticians," but all of whom "will have to deal with statistical studies and present their findings in an intelligible manner. He has in mind also the army of social workers who are expected to deal with facts rather than fancies." Most data used by statisticians are in all probability gathered in the field by just such individuals. Consequently it is well that they be versed in the procedures of gathering facts and arranging them systematically.

The greater part of the book is devoted to this end. There are chapters on the art of the statistical schedule and the subsequent tabulation of data drawn from the schedule. This is followed by a lengthy chapter on graphic presentation. There is a great deal of illustrative matter in the latter chapter, some of it good, more of it poor. The author's reason for the selection of data is that he desires his students to exercise critical judgment upon them. It is questionable, however, whether the elementary type of student for whom

the book is intended is in a position to analyze and recognize those psychiatric principles which enhance the value of one type of graph and detract from that of others.

The defect of the book lies in its assumption that sociology students have no more than a modicum of mathematical knowledge. Most of the users of this book, we are told, will have long since forgotten their algebra and most of them would be completely stumped by a problem involving the extraction of square root. To the reviewer this appears to be a severe indictment of the student rather than a justification of oversimplification of text. It seems, on the contrary, that the principles found in the average college textbook on statistics should be well within the grasp of every one who has had even the elementary courses in algebra required in high school.

The chapter on correlation is disappointing in that the student is shown how to find the coefficient of correlation from a paired series, but is left in the dark with respect to the treatment of the correlation table, which is the more usual arrangement. Again, there is no reason why the long-established term "coefficient of variation" should be abandoned for the coefficient of standard deviation, especially in view of the fact that the former is the recognized expression for the well-known measure of dispersion.

On the whole, it may be said that had the author kept in mind a higher type of student, the result would probably have been a more adequate text. At present the reader will profit most by the discussion of the presentation rather than the analyses of statistical data.

Benjamin Malzberg.

New York State Department of Charities.

Child Care and Training. By The Institute of Child Welfare. Minneapolis: University of Minnesota Press, 1928. 180 p.

There is no need to justify the publication of a book on child care and training. The field is such an important one, and there have been so few well-rounded attempts to meet the need for information with regard to it, that various approaches may be presented without fear of cluttering the market, while the experience gained from these various approaches is valuable.

In this book the staff of the Institute of Child Welfare at the University of Minnesota has brought together much generally accepted material, adding observations made at the institute itself. The book is a compilation of the individual discussions of an extension course, which is apparently so well organized that one is not conscious of gaps. The material is presented in a way that should make it comprehensible

to the average parent in comfortable circumstances, and the suggestions given are readily applicable to a parent at this social level.

Perhaps the greatest compliment that can be paid to this book is to state that the criticisms arising from a careful study of it are relatively few and for the most part of no great importance. The suggestion might be made that a great deal of already published material could have been added with advantage to the bibliographies presented. Also, it is to be regretted that such neurological terms as "nervous", "connections in the nervous system", and "nervous exhaustion" were not omitted in favor of the straight facts of behavior that they are supposed to represent.

The book is quite concrete and practical in that it suggests definite steps to be taken and things to be done. In the chapters on play and reading, specific articles are listed, so that the reader should have no difficulty in following out the more general suggestions. The book should be of value to the parent in helping him to prevent future trouble for the child and for himself. When serious problems have arisen, other approaches to these problems will have to be sought.

GEORGE S. STEVENSON.

The National Committee for Mental Hygiene.

GUIDANCE FOR COLLEGE WOMEN. By Mabelle Babcock Blake. New York: D. Appleton and Company, 1926. 280 p.

In his introduction to this book, President Neilson, of Smith College, says: "The most promising element in the educational movement of the present day is the *rediscovery of the individual student.*"

It is unfortunately true that in the development of mass education, administrators have been so concerned with curriculum, the raising of funds, advertising propaganda, and school policies that the real function of education has been almost obscured. In fact, the function of education needs to be redefined since the democratization of higher education. We are just coming through a period in which the attitude of the country as a whole toward higher education has been: "College for every one if possible." Critical minds have attacked this thesis, and much literature has been published on the question of cultural versus vocational education. Experimental psychologists have focused attention on individual differences to such an extent that one would no longer dare prescribe the same kind of educational opportunities for all students.

Not only is the line being drawn more sharply between those who ought to go to college and those who ought to learn a trade or pursue some definite vocation for which a college training is not necessary, but vocational guidance in college has been creeping in

more and more as a problem to be reckoned with. One sees only too frequently the sad picture of the educated youth, with his diploma tucked under his arm and a high idea of his accomplishments, who becomes a constant source of irritation to any industry because of his complete lack of information on practical subjects or training along practical lines.

In women's colleges especially a need has been felt for the formulation of final aims in education. Too many young women have gone to college because it was the mode, and without any intention of ever doing anything with their college education. However, as a result of increased difficulty of entrance, the introduction of intelligence tests, and long waiting lines, students as well as colleges have had to focus attention more directly upon what one expects to get out of a college education. "Culture" alone is no longer an adequate answer.

In her book, Dr. Blake, who is personnel director at Smith College, gives a comprehensive survey of the various methods of meeting this need in colleges for women scattered all over the United States. There are some special cases that serve to bring to mind clearly and specifically the varied problems which the college student and the college administration must meet. The plans extend all the way from a mere cursory mass examination to careful, detailed studies of the individual student by a competent psychiatrist. The book is not only an excellent summary of what is being done, but is suggestive and helpful to any one who contemplates preparing personnel work in colleges. The appendices give samples of questionnaires sent to secondary schools and record forms for keeping information in the personnel office. There is also a complete bibliography covering material which is either directly or indirectly related to the vocational guidance of college students.

Sadie Myers Shellow.

Psychological Department, The Milwaukee Electric Railway and Light Company.

Nervous and Mental Diseases for Nurses. By Irving J. Sands, M.D. Philadelphia: W. B. Saunders Company, 1928. 239 p.

This volume adds one more to the recent textbooks on nervous and mental diseases written for nurses. While in some respects the material is well presented, the general impression of the book does not allow one to recommend it.

The most important criticisms are as follows: There is considerable repetition of material. It does not seem necessary to present such conditions as general paresis, cerebral arteriosclerosis, and

the like under nervous diseases and then again under mental diseases. There are numerous errors and omissions throughout the book, and the attitude with regard to psychiatry is not one that the reviewer would advocate trying to teach our nurses at the present time.

In the chapter on elementary neuro-anatomy, the author states that all sensory tracts relay in the optic thalami. The olfactory pathway is specifically mentioned as doing this. The chapter on the glands of internal secretion can hardly be regarded as authoritative. Many things stated as facts are merely hypotheses. The discussion on the adrenal glands gives the impression that Addison's disease is produced largely by an involvement of the adrenal medulla and a diminished secretion of adrenalin. It is also stated that "the function of the parathyroid glands is to furnish to the blood a substance which renders harmless some poisons that exist in the body". There is no mention of parathormone or the function of the parathyroid glands in the control of calcium metabolism.

In the section on the forms of feeblemindedness, we are told that the average normal sixteen-year-old person has an intelligence quotient of 100 per cent; and in connection with trauma to the head, that if a fracture of the skull occurs, the patient is unconscious. Discussing epilepsy, the author startles us with the following expression of his opinion: "Furthermore, we personally do not believe in the theory that heredity plays the most important rôle in this disease; we have seen it in homes of the most intellectual and gifted people and even among royalty."

With regard to the treatment of mental diseases, the author varies from psychoanalysis to restraint, both of which receive his unqualified approval. In regard to psychoanalysis, we are told that the important thing is the abreaction; transference is not even mentioned. It is also somewhat difficult to reconcile the author's endorsement of psychoanalysis with the following statement: "We must never frighten a patient nor should we ever discuss any intense sexual situation with them."

The statement that depressed patients rarely attempt to drown themselves in a bath tub is not according to fact, and might cause nurses to be less careful and to take fewer precautions when bathing such patients. In the treatment of delirium tremens, we are told that the patient should be tied in bed. The continuous bath is not even mentioned. Restraint is constantly spoken of as a method of treatment, and the continuous bath and the pack are classified as forms of restraint. We are also told that a patient should never be kept in solitary confinement. Yet isolation by

secluding a patient in a room by himself is a measure employed in the best hospitals for mental diseases in this country. In the matter of the continuous bath, a nurse reading the book will be rather hopelessly confused as to the proper temperature. On page 183, "approximately 98°F" is stated to be the correct temperature. On page 228, a list of rules for the continuous bath are printed from which we learn that "the temperature of the water must not exceed 98°F and must not drop below 92°F, the ideal temperature being 96° F". On page 227, 95° to 100° F is given as correct. Further illustrations of the same sort might be cited.

We must conclude, therefore, that the book is too loosely and carelessly written and is full of too many errors and contradictions to be recommended as a textbook for nurses. From the psychiatric point of view, it does not seem to portray the best and most scientific methods.

KARL M. BOWMAN.

Boston Psychopathic Hospital.

SUICIDE PROBLEMS. By Frederick L. Hoffman. Newark: Prudential Insurance Company of America, 1927. 270 p.

This book, or large pamphlet, is for the most part a republication of statistical data gathered over many years by Dr. Hoffman, consulting statistician of the Prudential Insurance Company of America. Students of psychiatry and sociology have long been familiar with Dr. Hoffman's researches and will greet with a great deal of enthusiasm a volume that brings all of these together and thus furnishes a mine of statistical information.

The book deals for the most part with statistical tables gleaned from every corner of the world. Of particular interest are the suicide records of American cities running from 1896 to 1927. Dr. Hoffman finds that there is no longer an increase in suicide in America. Perhaps he does not attach enough importance to the influence of the war in checking the progressive increase in the suicide rate.

The introduction is largely concerned with the philosophy and ethics of suicide. This does not reflect a professional attitude toward the subject. For instance, in the discussion of one suicide, the statement is made that it probably would not have taken place had there been proper safeguards against the sale of dangerous weapons.

Although psychiatry is mentioned from time to time, it is practically ignored in the discussion of illustrative cases. Commonplace causes are sought. One man states that no cause could be assigned

for the act except that he suffered excruciating pains. The few cases cited with which the reviewer is familiar show a lack of understanding of the fundamental mental mechanisms back of suicide.

As a collection of statistical data, the book will always be of value; as a philosophical treatise on suicide, it will merely serve to perpetuate a lot of superstitions which advanced thinkers have long since rejected.

A. Warren Stearns.

Tufts Medical School.

Epilepsy; Comparative Pathogenesis, Symptoms, Treatment. By L. J. J. Muskens, M.D., with a foreword by Sir Charles S. Sherrington. New York: William Wood and Company, 1928. 650 p.

Dr. Muskens needs no other recommendation to those who are not familiar with his work than that given by Sir Charles Sherrington. In this monograph on epilepsy he has covered the field in thorough, painstaking manner. The first 194 pages are given over to a comprehensive review of the literature bearing on experimental investigation and the recording of his own laboratory investigations, while the second part of the book is concerned with clinical observations. This portion is of much more practical value to the physician. Part III is entitled *Epileptic Disorders Observed in Man and Their Treatment.*

Dr. Muskens' approach to the subject is that of the physiologist; he is obviously "organically minded". The entire monograph shows very clearly the influence that men like Hughlings Jackson, Gowers, and Horsley have exerted on his training, yet he has not ignored the psychogenic aspects of the convulsive disorders.

Some of the chapter headings will indicate how extensively he has covered the subject: Chapter V.—*Tonic Spasms and Convulsions in Childhood and Their Significance for the Development of Epilepsy;* Chapter VI.—*Influence of Menstruation and Pregnancy in the Occurrence of Epilepsy;* Chapter VIII.—*The Relative Frequency and Nosological Value of the Symptoms;* Chapter IX.—*The Statics of Epilepsy;* Chapter X.—*Differential Diagnosis;* Chapter XII.—*Treatment;* Chapter XIV.—*Traumatic Epilepsy and Surgical Treatment;* Chapter XV.—*A System for the Prevention of Epilepsy and for the Care of Epilepsy.*

Dr. Muskens has presented his subject in a most interesting and practical way. He has brought to bear a keen scientific mind in criticizing the contributions of others. One is impressed by the painstaking and detailed account of the experimental work recorded,

and by the fact that he obviously knows the epileptic as well as the condition we term as epilepsy. As a book both of reference and of practical value to the clinician, it can be highly recommended.

D. A. Thom.

Tufts Medical School.

Clinical and Abnormal Psychology; A Textbook for Educators, Psychologists, and Mental-Hygiene Workers. By J. E. Wallace Wallin. Boston: Houghton Mifflin Company, 1927. 649 p.

In this companion volume to the author's *The Education of Handicapped Children*, the emphasis is on "psychological methods and diagnostic technique with a consideration of the causes for and the educational implications of each type of mental defect". Whereas the purpose of the book is to present to the student a systematic "purview of the entire field" of clinical and abnormal psychology, it is avowedly "sympathetic toward a behavioristic approach". This is not to say, however, that it represents the point of view of an extremist; although the dynamic psychologies are by no means in the ascendant, neither are they disregarded. In accordance with Dr. Wallin's primary aim, both the structural and the dynamic concepts of human behavior are given a place as organized systems.

A threefold study of the individual is, in the opinion of the author, necessary to a complete understanding of a given problem. Accordingly, there are three divisions of subject matter into intelligence, motility, and emotivity. In each of these three sections, the main emphasis is on diagnostic measurement and the description of symptoms that mark the deviate. The consideration of causative factors is attempted from the physiological, structural, and dynamic points of view whenever possible, but it is obvious that more than a cursory consideration is impossible. One cannot but feel from time to time that too much material has been compressed into this volume; that either psychological methods and diagnostic technique, or causes for and educational implications of each type of mental defect, would be matter enough for one book; but that when both are included and the discussion of causation is furthermore multiplied fourfold by systematic treatment, issues become blurred even while the author's style is unmistakably clear and simple.

The student will find the chapters devoted to individual and group tests of intelligence particularly valuable. The presentation of controversial concepts of intelligence, the full evaluation of quantitative methods of measurement, and the highly socialized point of view from which the interpretation of test scores is considered, are

outstanding. The section on motility describes the physiological mechanisms that underlie motor abilities, as well as the test apparatus devised to measure them. The illustrations of physiological measuring instruments and of performance tests enhance the value of these chapters.

In the section on emotivity, the bulk of the material is concerned with objective examinations evaluated in so far as possible in the light of scientific research. The results are so at variance, so doubtful in their significance, that here more than elsewhere in the book one wishes for a thoroughgoing examination into the dynamic factors behind emotional response, personality traits, and character development. They are hinted at, but never explained in such a way as to relate, for example, the discussion of deviations in associative processes, imagery, and attention, which are categorically treated under intelligence, to the chapters on emotivity two hundred pages later. And yet had that been done, the non-diagnostic nature of most of the so-called tests of emotions and character would be self-explanatory.

While one admires greatly the practical qualities of the sections that deal with diagnostic technique, the academic air that marks the description and classification of pathological symptoms runs counter to the mental-hygienist's attempt to break through the crust and reach the core.

JEANETTE REGENSBURG.

New York School of Social Work.

THE ELEMENTS OF CRIME (PSYCHO-SOCIAL INTERPRETATION). By Boris Brasol. New York: Oxford University Press, 1927. 443 p.

In this volume Mr. Brasol, formerly prosecuting attorney to the St. Petersburg Supreme Court, attempts a very full and comprehensive inquiry into the nature and causes of crime, including an exhaustive examination of both social and personal factors.

The presentation is in two parts, the first dealing with crime as a "social phenomenon" and the second treating of its more significant "psycho-physical" implications. Introductions, it might be mentioned, are supplied by Professor John H. Wigmore and Dr. William A. White.

In the first section, after a preliminary introductory chapter, the author proceeds to a consideration of the following special topics: the genesis and nature of the criminal propensity, economic factors, religion and the family, education and the press, and problems of legislation and procedure. In this first part, emphasis is laid upon the important egocentricity component of the so-termed antisocial

tendency, this being characterized specifically by three qualities—disregard of social requirements, a "following of the line of least moral resistance", and lack of "remorse". Crime is finally defined by the author as "a deed, prohibited and punishable under the laws of a particular state, constituting a willful attempt on the part of the individual against the existing social order, and that factor which controls the coördination of the heterogeneous elements, of which society is the synthesis". In this connection, proper and necessary stress is given the causal multilaterality, so to speak, of criminal reaction and the importance of both immediate and remote factors, social, economic, and personal.

Brasol also makes some interesting comments on the possible unfavorable influence upon criminalism of "modernistic" tendencies within the church, and stresses the admittedly important relationship of the effects of family disintegration. Regarding the rôle of education, the author feels that there has been here a seriously detrimental neglect of essential religious, ethical, and æsthetic emphases.

As for the press, after careful and searching analysis, the conclusion is reached that, on the whole, the situation might be much worse. However, Mr. Brasol does point out a real need for continued and closer scrutiny of the type and volume of publicity given to crime. Thus he states: "From the standpoint of criminology the principal danger of perverted publicity is its ultimate demoralizing effect upon social psychology. Examined from this angle, indiscriminate journalism unquestionably occupies a prominent place among the factors which either cause or encourage the growth of the criminal propensity leading to the crystallization of the '*milieu criminel*'."

The discussion of personal or "psycho-physical" aspects is a full one, according merited significance to the criminogenic possibilities inherent in human nature and personality relations. In this connection, the personal element is very pertinently epitomized, thus: "the delinquent . . . is not only the author of the prohibited and punishable deed, but, as it were, a germ carrier of that antisocial energy, the discharge of which constitutes the crime itself". This is followed by a discussion of "responsibility", with some very interesting material bearing upon prevailing concepts and procedures, especially in certain European centers. There is further included a comprehensive description of the more important psychopathologic states, particularly in their relation to criminal and antisocial conduct.

To sum up, Mr. Brasol's book impresses the reviewer as a funda-

mentally sound and in some ways really interesting contribution, but at the same time it must be said that it adds but little to the concept of criminality as such. Also the effort to cover too much ground in the space available, and in too great prolixity of detail, definitely detracts from the clarity and readability of the work and therefore from its force and effectiveness.

THEOPHILE RAPHAEL.

Psychopathic Clinic,
Recorder's Court, Detroit.

AN INTRODUCTION TO FORENSIC PSYCHIATRY IN THE CRIMINAL COURTS. By W. Norwood East. New York: William Wood and Company, 1927. 381 p.

CRIME AND INSANITY. By W. C. Sullivan. New York: Longmans Green, and Company, 1924. 259 p.

These two books, both of them by Englishmen, are of a kind. Both of them attempt to adapt psychiatry to the requirements of the legal system as it stands. Both of them cite great numbers of cases to illustrate crime occurring in the course of and presumably as a direct manifestation of the various major psychotic entities. For this reason they afford interesting collections of criminal cases in which the "insanity" of the criminal is beyond serious question. Of the two, East—who is a lecturer on criminology at Maudsley Hospital and medical inspector of the prisons in England and Wales—gives much the more carefully selected and completely recorded cases.

Both of them sadly lack any evidence of having grasped the modern problems of criminology and of psychiatry as it relates to crime. Neither of them has anything to say about the actual motivation of crime, or the contributions of psychiatry in the improved disposal of the convicted criminal. Both of them assume that a guilty criminal goes either to jail or to the asylum—that it is a question of punishment or commitment. No other issues seem to have disturbed either author. The fact that a criminal whose antisocial propensities are the result of a personality upset of the type that is classifiable in the psychotic categories is relatively rare does not seem to have stimulated either author to attempt a broader view of the psychiatric aspects of crime.

So it stands that here we have two English books almost as bad, if not a little worse, than some of the recent American books on criminology written by psychiatrists. The English books are a little better in that their cases are better selected, but they are a little worse in that the American books have at least a broader conception of the field, even although few of them contribute much to a better understanding of it. It is quite significant and typical of both books that

Dr. Sullivan is described as being the medical superintendent of the Broadmoor *Criminal Lunatic Asylum.*

Topeka, Kansas. KARL A. MENNINGER.

THE INVERT. By "Anomaly". With an Introduction by Robert H. Thouless. London: Baillière, Tindall, and Cox, 1927. 159 p.

Books in English on sexual inversion are far from numerous, and there has long been a need and a demand for such a volume as *The Invert.* It fills most adequately the *lacuna* between the scientific work of Havelock Ellis and the literary presentations of John Addington Symonds and Edward Carpenter.

The Invert is, in the best sense, popularly written. It is addressed, as the author states, primarily to the sexual invert, and secondly to the normal reader. To the latter it should provide a basis for his better understanding of a sexual anomaly of which he probably knows little that is either correct or fair, but with which he sooner or later is likely to come into personal contact. And to the invert himself, and particularly to him who is bewildered or distressed or discouraged by his abnormality, the book will come as a very real comfort and help in his effort to orient himself, in work and in play, to a world that does not as yet recognize the invert as a useful and in many ways indispensable member of society. To many readers the book may appear unnecessary, so familiar with and tolerant to homosexuality have certain large sections of the public become; and it is to be feared that a great mass of educated people will never encounter this little volume. It is to be hoped, on the other hand, that it will reach teachers, doctors, clergymen, social workers, and business men, who, in their turn, may pass on to those with whose problems they are faced the excellent counsels to be found in *The Invert.*

"Anomaly" raises the usual questions as to the cause and nature of sexual inversion, its "cure", and its prevalence, all of which he wisely refrains from discussing in any detail. He makes one interesting plea, however: that later studies of inversion should not include bisexuality under the heading of true inversion, but should pursue an independent research. He feels that, while closely related, the two phenomena should be kept strictly separate in their scientific and social treatment.

The Invert should find its way into the libraries of all those who come in direct contact with numbers of their fellow men. It is a highly valuable, sane, and readable work by an invert—a fact that to the present reviewer only enhances and underlines, as it were, the wholly admirable motive for, and execution of, a long-looked-for book.

Providence, Rhode Island. S. RIGGS.

THE SMALL GENERAL HOSPITAL. By W. S. Rankin, H. Eldridge, and H. P. Van Arsdall. Charlotte, N. C.: The Trustees of The Duke Endowment. 77 p.

This monograph represents the collaboration of competent architects with well-known superintendents of general hospitals. It is excellently arranged and printed and contains architects' plans and illustrations in considerable detail, so as to be of the greatest possible use to those who are planning to build small general hospitals in the Carolinas. It would doubtless serve equally well in other climates, since it deals, not with those phases of construction that have to do with immediate climatic conditions, but rather with the arrangement of interiors and the fixed equipment. Its object is, first, to give information with regard to the general principles of hospital planning for the general public and non-technical groups; and second, to supply more detailed information and designs for the use of building committees and technical groups who are more directly concerned with the planning, designing, and building of hospitals. It is designed to be adaptable to the varying needs and conditions of different communities.

We find careful estimates of the number of beds that a hospital should provide for communities of given sizes in either rural or urban surroundings. There is even a note on the special conditions for which beds will be needed and the number required for each. These special conditions are contagious diseases, diseases of children, maternity cases, and tuberculosis. No mention is made of mental illness. Two assumptions are everywhere prevalent on this topic: one is that there is no mental illness in the community, because every case is or has been removed to some mental hospital maintained by the state; the other is that any patient with a mental disorder is disturbing to those who have no mental disorder, and therefore, no matter how many of such patients there be in the community, they should not be, and are not, admitted within the walls of the general hospital. Both assumptions are ludicrously false. As regards the first, it is well known that many families delay until the last possible minute the removal to the state hospital of the mentally ill among their members, either because of humiliation over the existence of a type of illness that is considered disgraceful, because of the distance of the mental hospital, or because of the feeling that those who go to a mental hospital can never be expected to improve sufficiently to come home again. As to the second assumption, all that is necessary to do is to examine the patients in any hospital ward to find that there are those among them whose problems are quite as much mental as physical.

Not many years ago the class of patients known as the tuberculous would have received as scant attention as mental patients do now; but tuberculosis is no longer considered a disgrace, and the principles of hospital treatment of the disease have been quite well established. There is need of the same process of education with regard to mental illness. Certainly, an early step toward reform in these matters is a recognition of the fact that problems of mental illness are all about us, are already found in the general hospitals.

Additions to the hospital in later years receive consideration in the monograph: enlargements for general hospital purposes, provision for cases of tuberculosis and infectious diseases, and nurses' home. Even in this matter of additions, no thought is given to the mental patient. Yet the prevalence of mental disorders is evident in the fact that the number of patients in mental hospitals in the United States is greater than the number in all the other hospitals combined.

An important chapter in the book deals with service relations, the theme being that traffic and service must be properly managed, else the hospital fails to function satisfactorily.

The second and larger section discusses the size, location, arrangement, and finish of the essential units of the hospital, and offers suggestions regarding workmanship and economies in construction. Lists are presented covering details of construction and finish and the furnishing and equipment of the various units. Each section begins with a brief statement of the purpose of the unit discussed. Future extensions of the institution receive appropriate consideration here.

The third section contains drawings, showing exteriors, interiors, and floor plans of buildings for hospitals of the various sizes in question.

To repeat, this is an admirable monograph. One only hopes that when it is revised, consideration will be given to a group of patients who in one way or another will find admission to the general hospital, but who are not so well provided for now as they should be.

Samuel W. Hamilton.

Bloomingdale Hospital.

The Influence of Music on Behavior. By Charles M. Diserens. Princeton: Princeton University Press, 1926. 224 p.

This scholarly thesis, by the assistant professor of psychology at the University of Cincinnati, is an attractive presentation of a subject that touches psychiatry at several points. The author approaches music from the practical rather than from the æsthetic standpoint, he says, regarding it as a necessity, a possible means of reëducation and

human reconstruction, rather than as a mere subject of unproductive pleasure or an object for criticism from the learned few; and his method is both genetic and experimental. Considering music as including everything from the stridulating notes of insects through the most ambitious productions of the human vocal chord, he maintains that musical utterance is a eugenic factor. He gives measured approval to Darwin's view that musical tones and rhythm were first acquired for the sake of charming the opposite sex, but discusses war and work songs as well, and postulates that music comes from phylogenetic associations with two great primary impulses—the sex and the herd instincts.

In interesting anecdotal fashion he discusses the reaction of animals to music, a subject on which a considerable, but scattered mass of data exists. A chapter is devoted to myths about music and musicians, in which such well-known and widely distributed legends as those of the sirens, Orpheus, and the Pied Piper are reviewed and many less well-known are recalled to the reader's memory. The modern who has left a symphony concert with a feeling of rapture and awe, will not, perhaps, find it hard to understand how the ancients could think that sand was changed into diamonds, that haycocks stored themselves in barns, and that the rain was made to fall through the influence of music. Amphion's divine music raised the walls of Thebes and the divine minstrel of the Guianian Indians rescued despairing man from the deluge by the magic of his snake-skin drum, beating so rhythmically that the waters gradually sank delighted into the sea, and the rocks arose to listen.

There is an important chapter on "music in magic". Primitives are suffused with emotion through the mimetic and dramatic processes. They identify the force with the object, and distinguish two classes of stimuli—the natural and the mysterious. Hence, they mistake the order of their ideas for the order of nature, and imagine the same control for both. Primitive man had great confidence in the power of his wishes. Whatever evoked powerful movement thereby brought a feeling of omnipotence to its maximum; now this is one of the characteristic effects of music. Musical effects must have been greater on primitives than on the cultured, and musical images must have seemed to be objective realities. The author refers to certain data on colored hearing, which, he says, is less infrequent than is commonly supposed and may have played a rôle in the evolution of animistic philosophy. He notes, also, that a certain school of moderns has a complete scheme of identities of vowels, tones, colors, and abstract concepts; and several moderns compose according to magical principles.

The influence of music on work lends itself to more detailed obser-

vation and more careful experiment than music in the other fields just discussed. Primitives love idleness, but have to do much work in order to exist; and all over the world they sing as they work and thereby increase their activity. Civilized persons pursue the same course, perhaps less strikingly. Music stimulates nutritive processes, corrects poor posture, and by strengthening muscular contraction, increases the blood supply, promotes nutrition, and improves muscle tone. Experiments were made in this field as far back as the eighteenth century. Dr. Diserens also has carried out some carefully observed experiments in which he has used not isolated musical elements, but musical compositions; and has recorded the result on (1) habitual voluntary reactions, (2) voluntary reactions involving attention and judgment, and (3) involuntary reactions. His conclusions are carefully drawn and not overstated.

We speak last of his discussion of the influence of music on the sick, though in the volume this is a median chapter. The conception that there is a musical therapy dates from the remotest antiquity and is current among practically every primitive or semi-primitive people of to-day. Pythagoras directed that certain mental disorders be treated by music. Celsus, Coelius Aurelianus, and others are quoted. Arabian hospitals in the thirteenth century had music rooms with musicians constantly playing. Distinguished royal patients have been treated in this fashion and have at least professed to get great solace from the treatment. Most prescriptions have been general, and those who have taken the trouble to write about musical therapy have been inclined to claim more than present-day experience would seem to warrant, for we are disinclined to prescribe music for the cure of aphasia, apoplexy, epilepsy, and the like, as some older writers aver they have done. A plausible explanation offered is that the therapeutic effects of music are due to association. Certainly the revival of musical therapy indicates a belief that it actually produces favorable changes in the organism; and a relatively simple theory of its action is that by agreeably occupying the higher centers, music leaves the sympathetic nervous system free from interference. The chapter on musical therapy is largely anecdotal in character.

Let us leave this book with the statement that not only is it interesting to the casual reader, but it should be studied by those who are planning to make use of music in any way in relation to the sick. The reviewer ventures the hope that it will stimulate others to make careful observations of the use of music in hospitals for the mentally ill. Probably there are few hospitals that utilize music in the daily life of their patients nearly as fully as sound experience shows to be possible and desirable. Some one with a background of adequate

experience in the care of the mentally ill and adequate knowledge and appreciation of music should some day take up this theme and set forth in authoritative fashion what can and what cannot be accomplished in this field.

May we not hope that music, like other useful disciplines, may be developed into a therapeutic measure comparable to physiotherapy, athletics, and occupation therapy?

SAMUEL W. HAMILTON.

Bloomingdale Hospital.

MENTAL AND SCHOLASTIC TESTS. By Cyril Burt. London: P. S. King and Son, 1927. 432 p.

This is a third impression (November, 1927) apparently from the same plates, throughout, as the second impression (September, 1922), which was reviewed in MENTAL HYGIENE, July, 1924.

During an interim, in which this book was out of print, the publishers "reprinted" from it the *Handbook of Tests* of 106 pages, "with a new preface and instructions to teachers how to use the tests".

New York City. THOMAS H. HAINES.

PRACTICAL CLINICAL PSYCHIATRY FOR STUDENTS AND PRACTITIONERS. By Edward A. Strecker, M.D., and Franklin G. Ebaugh, M.D. (Second edition enlarged and revised with illustrations.) Philadelphia: P. Blakiston's Son and Company, 1928. 458 p.

Drs. Strecker and Ebaugh have made some splendid improvements in the second edition of their already valuable textbook *Clinical Psychiatry*. The case method of presentation not only pictures the various psychoses more clearly than a generalized discussion, but also emphasizes the individual variations and the importance of thorough study, not only of presenting symptoms, but of hereditary and environmental factors and the personality make-up of the individual before the psychosis.

In this edition this approach is aided by an excellent brief discussion of etiology, of the relationship of physique to type of personality, and in many instances by an introductory discussion before cases are presented.

Therapy is more fully described, especially in the addition of a detailed account of the malarial treatment of general paresis, with clinical summary of results.

The concise and sound advice regarding the handling of behavior problems in post-encephalitic children is forward-looking in its preventive emphasis.

Schizophrenia receives more adequate treatment in this volume than in the first edition, and the reviewer wonders why the chapter title was not changed from *Dementia Praecox* to the newer term, which is frequently used in the text and is admittedly more accurate and desirable.

The chapter on the psychoneuroses has been vastly improved by the addition of much case material and a fuller explanatory text.

It seems unfortunate that such a careful presentation of subject matter should not have been more carefully proof read so as to avoid the rather numerous omissions of letters and mistakes in punctuation. With these exceptions, however, the book deserves unqualified praise and recommendation for the student or practitioner who wishes a concise and accurate handbook of mental disease.

In conclusion, this second edition is a great improvement on a book whose first edition was excellent, so that we now have a concise and yet thorough treatment of clinical psychiatry. To me it now represents the best small book published upon clinical psychiatry.

Arthur H. Ruggles.

Butler Hospital.

The Inner World of Childhood; A Study in Analytical Psychology. By Frances G. Wickes. New York: D. Appleton and Company, 1927. 372 p.

The contribution of the psychoanalyst to the understanding of the mental life of the child is becoming more and more illuminating. The author of *The Inner World of Childhood* has had considerable experience as a teacher. She shows strongly the influence of both Adler and Jung.

Aside from an analysis of the various abnormal manifestations on the part of the child from an orthodox analytical point of view, Mrs. Wickes gives a wealth of specific material drawn from her large experience. Of special note is her stress on the effect on the child of the undercurrent in the home. Attitudes and feelings repressed by the parent in order that the child may not suspect them are quickly sensed by the child. The author emphasizes the importance of the parents' straightening out their own difficulties satisfactorily in order that the child shall not bear the burden of his parents' maladjustment. There is a very good chapter on adolescence. Other topics discussed are imaginary companions, fear, sex, and dreams, and there is a final chapter on a correlation of dream and phantasy material.

There is very little in the book that is new to those who are familiar with the analytic point of view. The many short summaries serve to make the explanations more vivid. The style is easy and pleasant.

The book on the whole is a very good one to recommend to parents who are trying to understand the problems of their children.

Sadie Myers Shellow.

Psychological Department, The Milwaukee Electric Railway and Light Company.

The Prohibition Mania. By Clarence Darrow and Victor S. Yarros. New York: Boni and Liveright, 1927. 254 p.

This very unsatisfactory book was written to refute the arguments set forth in Irving Fisher's book, *Prohibition at Its Worst.* In preparing their arguments the authors evidently did not deem it worth while to make a careful inquiry into the effects of the liquor traffic at any time, or into the effects of prohibition on the liquor traffic or on social welfare. The book presents practically nothing new and very little that has not been better stated elsewhere. It consists principally of unverified opinions, statements, and quotations of doubtful value. To one who seeks definite data on which to base conclusions, it is disappointing to find unsupported statements such as the following: "The great majority of civilized, educated, and cultivated people use liquor to-day." "The great majority of the men of science drink intoxicating beverages in moderation. . . . The same is true of the overwhelming majority of professional and business men." " The opponents of prohibition are not obscurantists or standpatters. On the contrary, they are among the most progressive elements of the population, who encourage and promote science and culture in every way, and if science should ever arrive at the definite conclusion that alcohol in any quantity is physically or morally and socially seriously injurious, they will be among the first to urge individuals to abstain from the use of alcohol." "There never were statistics of any value showing the relation between crime and intoxicating liquors. There is no appreciable relation and there never has been."

These few quotations give a sample of the authors' style and method of argument. There is throughout sharp criticism of Professor Fisher's deductions, but little constructive discussion.

Those who think that a great social question can be solved by a lawyer sitting at his desk and writing denunciatory statements concerning everything that interferes with his personal desires will naturally want to read this book; on the other hand, those who desire accurate information on the great problem of the control of the liquor traffic will have to look elsewhere.

Horatio M. Pollock.

New York State Department of Mental Hygiene.

THE EXAMINATION OF THE CENTRAL NERVOUS SYSTEM. By Donald Core, M.D. New York: William Wood and Company, 1928. 248 p.

This book was produced to assist the neurological student in developing a thorough and systematic method of examination of neurological cases. The author has kept to this purpose by relating clearly and in moderate detail the clinical symptoms produced by disease and the method of testing the integrity of the various components of the nervous system.

The major portion of the book is devoted to the description of a method of systematic neurological examination, and the technic for making the various tests is clearly explained. Emphasis throughout is placed on the clinical interpretation of symptoms. No attempt is made to establish syndromes for the various diseases, but symptoms are sufficiently discussed to illustrate the particular phases of examination under consideration. In like manner neuro-anatomy and neuro-physiology are but lightly touched upon. The chapters on the cranial nerves and on aphasia are particularly well done. The examination of the mental state of the patient is briefly outlined and is of value in as much as it relates the major clinical manifestations of psychic disturbances and tells what to look for. The diagnostic value of the X-ray, the cerebro-spinal fluid, and the blood pressure and the clinical significance of the more common pathological states are briefly discussed. The concluding chapters deal very briefly with the subject of differential diagnosis and, while incomplete, contain some valuable diagnostic hints.

The book is clearly written; it is easy to read and to understand. It deals with a phase of clinical neurology—the technic of examination—which is given but little consideration in the more complete texts of neurology and should, therefore, not only be of value to the neurological student, but should also assist the general practitioner in the detection of neurologic involvement.

P. E. KUBITSCHEK.

Child Guidance Clinic, St. Louis.

NOTES AND COMMENTS

Legislative Notes

The following summary of 1929 legislation is divided into two parts, bills that have become law and bills that failed. In each part the bills are indexed according to subject and listed alphabetically by state. Bills of purely technical or local interest are not listed. In the case of those that have become law, both the designation of the bill and the chapter of the law are given when known.

NEW LAWS

Index by Subject

Administration and Finance
Indiana S. 26; Maine S. 669; Massachusetts H. 1256; Montana H. 314; Nevada H. 187; New Hampshire H. 173; New York H. 800; S. 90, and S. 173; Oregon H. 573; Pennsylvania S. 5.

Commitment
Connecticut H. 409; Massachusetts S. 221; New York H. 800 and S. 646.

Criminal Insane
Montana H. 314.

Delinquent, Defective, Dependent, Psychopathic, and Maladjusted Children
Colorado H. 158; Iowa S. 174, and S. 175; New Jersey H. 207; New York H. 800 and S. 370; Ohio S. 172; Oregon H. 573.

Epileptics
New York S. 173.

Examination of Prisoners and of Certain Persons Accused of Crime
California S. 207; Delaware S. 33; New York H. 784.

Feebleminded, Care of
Nevada H. 160; Utah S. 51.

Guardianship
Maryland S. 72; New York H. 1052.

Insanity Pleas in Criminal Cases
California S. 207.

Marriage and Divorce
New York H. 787.

Miscellaneous
Minnesota S. 226; New York S. 553; U. S. Congress H. 16436.

New Institutions and Clinics
California H. 523; Montana H. 314; New York H. 784 and H. 1776; Pennsylvania S. 5; Utah S. 51 and S. 88.

Special Classes for Retarded Children
New York S. 370.

Sterilization
Arizona S. 34; Delaware S. 32 and S. 33; Maine S. 112; Michigan H. 203; Nebraska S. 197.
Veterans
Maryland S. 72; Michigan S. 274; Utah S. 3.
Voluntary and Emergency Admission
Connecticut H. 409; Rhode Island H. 909.

Arizona

S. 34. Provides for the sexual sterilization of any patient confined in the state hospital for the insane "afflicted with hereditary forms of insanity that are recurrent, idiocy, imbecility, feeblemindedness, or epilepsy". It should be noted that this act includes all of the above mentioned persons under state care, inasmuch as they are all confined in this institution.

California

H. 523, Chap. 683. Provides for the establishment of a state hospital for the insane in southern California.

S. 207, Chap. 385. Relates to insanity pleas in criminal cases. Summarized in April number of MENTAL HYGIENE.

Colorado

H. 158. Provides that no mental incompetent under the age of sixteen years shall be committed to the Colorado State Hospital in the event that the Ridge School, the Grand Junction Home, or the Colorado Psychopathic Hospital has accommodation for him.

Connecticut

H. 409. Amends Chapter 110 of the Public Acts of 1921 by providing that any person who has suddenly become in need of care and treatment in a hospital for the insane may be confined in such hospital, either public or private, for thirty days, rather than for twenty days, without order of any court, and that notification of both the emergency commitment and the court commitment, if this be found necessary, shall be made to the comptroller rather than to the department of state agencies and institutions, as formerly.

Delaware

S. 32. Amends the sterilization law by including the mental-hygiene clinic of the Delaware State Hospital at Farnhurst and the superintendent of said institution among those authorized to recommend sterilization.

S. 33. Amends the sterilization law by providing that "all habitual

or confirmed criminals who have been convicted of at least three felonies by any court of this state or of the United States, or of any other state, shall be subject to observation and examination by the mental-hygiene clinic, or the superintendent of the Delaware State Hospital at Farnhurst''. If, on such observation and examination, it be found that any such person's criminality is caused by mental abnormality or mental disease, the board of trustees or other governing body, as the case may be, is authorized to apply to the state board of charities for the sterilization of such person.

Indiana

S. 26, Chap. 89. Permits the state to levy charges for the treatment of insane persons against the patient's estate if there are no near relatives.

Iowa

S. 174. Makes the penalty for contributing to juvenile dependency equal to that for contributing to juvenile delinquency.

S. 175. Amends the definition of dependent and neglected children by making it include any child who ''is living in a home wherein because of carelessness or neglect of a person or persons having a transmissible disease of a serious nature . . . the health of the child may be in danger''.

Maine

S. 112, Chap. 6. Amends the sterilization law by permitting the guardian to give consent in case the patient is mentally incompetent.

S. 669. Provides for the licensing and regulation of private hospitals and private houses for the treatment of patients mentally deranged.

Maryland

S. 72, Chap. 74. Provides for the guardianship of incompetent veterans and of minor children of disabled or deceased veterans, and makes uniform the laws pertaining thereto.

Massachusetts

H. 1256, Chap. 322. Authorizes the department of mental diseases to take or purchase land in the city of Waltham and the towns of Belmont and Lexington for the proposed Metropolitan State Hospital.

S. 221, Chap. 136. Provides for observation and commitment to federal hospitals for the insane.

Michigan

H. 203. Amends the sterilization law so as to permit of sterilization without consent of the patient, in case the patient is mentally incompetent.

S. 274. Provides for the guardianship of incompetent veterans, etc.

Minnesota

S. 226. Makes it a felony to abduct or carry away any feebleminded person committed to the guardianship of the state board of control from any institution or place.

Montana

H. 314. Appropriates the sum of $112,008.00 for the purpose of constructing, furnishing, and equipping a house for the criminal insane, living quarters for the attending physicians, and an addition to the heating plant at the Montana State Hospital for the Insane.

Nebraska

S. 197. Repeals certain sections of the sterilization law, notably that requiring consent of parent, guardian, or next of kin; provides for the sterilization of habitual criminals, permitting them, when sterilized, to appeal for parole after one year; and places the authority in such cases in the hands of the "board of control", this term being substituted for "examining board".

Nevada

H. 160. Provides for the care and education of feebleminded children, the expenses to be paid, when necessary, by the county of residence of the child. The county commissioners of the various counties are required to make all contracts and arrangements, which may be made with any responsible parties or institution, in or without the state of Nevada.

H. 187. Authorizes the board of capitol commissioners to make needed improvements and repairs upon the building and equipment of the Nevada State Hospital for Mental Diseases, and appropriates $19,500 therefor.

New Hampshire

H. 173. Appropriates $200,000 for the construction and equipment of a dormitory for disturbed male patients at the state hospital.

New Jersey

H. 207, Chap. 53. Amends the juvenile-courts act so as to permit municipalities maintaining no home for the detention of juvenile

offenders to contract with other municipalities maintaining such homes.

New York

H. 784, Chap. 242. Provides for a psychiatric clinic at Sing Sing Prison for a scientific study of each criminal and recommendations for the care, training, and employment of criminals.

H. 787, Chap. 537. Amends the domestic-relations law, in relation to the annulment of a marriage on the ground of incurable insanity, as follows: (1) provides for the filing and recording of the instrument creating the security for an insane wife's care and maintenance during life; (2) strikes out the provision that one of the three examining physicians shall be the superintendent of a state hospital for the insane, and provides that all three, instead of only two, of the examining physicians shall be appointed by the court; and (3) adds the following: "When a person alleged to be incurably insane is confined in a state hospital for the insane, one, and only one, of the physicians so appointed shall be a member of the resident medical staff of such hospital designated by the superintendent thereof. If the alleged incurably insane person is not confined in a state hospital for the insane, one of the examining physicians named in pursuance to this section shall be the superintendent of a state hospital for the insane."

H. 800, Chap. 136. Amends the mental-hygiene law by including the Court of Special Sessions of the City of New York among those agencies which may order commitment to an institution for mental defectives of a mentally defective person not over sixteen years of age who is charged with misdemeanor.

H. 1052, Chap. 335. Amends the real-property act by extending the requirement of appointment of a committee of property of an incompetent to include "a person incompetent to manage his affairs by reason of imbecility arising from old age or loss of memory and understanding".

H. 1776, Chap. 549. Establishes, in Suffolk County, a state hospital for the care and treatment of the insane, to be known as the Pilgrim State Hospital, "in recognition of the devotion of Charles Winfield Pilgrim to the care of the insane in New York State".

S. 90, chap. 63. Amends the mental-hygiene law by defining "resident" to be a person who has lived in the state at least one year "continuously".

S. 173, Chap. 550. Amends the mental-hygiene law relative to Craig Colony for Epileptics. Summarized in the April number of MENTAL HYGIENE.

S. 370, Chap. 258. Amends the education law by extending the

provision for special classes for retarded children to all such children rather than to those only who are three years or more retarded, and by placing the establishment of special classes under rules to be established by the state education department.

S. 553, Chap. 379. Authorizes the land board to surrender to the city of New York a part of the premises and structures on Ward's Island, now occupied by the Manhattan State Hospital.

S. 646, Chap. 172. Amends the mental-hygiene law relative to temporary and voluntary admission of mental defectives. Summarized in the April number of MENTAL HYGIENE.

Ohio

S. 172. Amends the general code relative to medical examinations in juvenile courts, so as to include examinations by psychiatrists and psychologists.

Oregon

H. 573, Chap. 416. Provides for the support of homeless, neglected, and abused children and indigent orphans under the age of sixteen years, cared for by benevolent or charitable institutions in Oregon, for the support of wayward girls, and for the care of maternity and venereal cases, appropriating money therefor, and declaring an emergency.

Pennsylvania

S. 5. Authorizes and regulates the establishment and operation by counties of hospitals for the treatment of women afflicted with nervous diseases.

Rhode Island

H. 909. Provides for emergency and voluntary admission of patients to the psychopathic ward of Providence City Hospital.

U. S. Congress

H. 16436, Act 935. Provides for the repatriation of insane American citizens in Canadian asylums.

Utah

S. 3. Pertains to the guardianship of incompetent veterans, etc.

S. 51. Provides for the establishment of the Utah State Training School for the Feebleminded.

S. 88. Provides for the establishment, maintenance, and control of "a home for fallen women".

BILLS THAT FAILED

Index by Subject.

Administration and Finance
Michigan S. J. R. 6; New York H. 1823; Washington S. 136 and S. 216.

Deportation
Maine H. 1543.

Guardianship
Pennsylvania H. 227.

Marriage and Divorce
Arkansas H. 139 and S. 65; Maryland H. 84.

Miscellaneous
New York H. 1160; U. S. S. 5602.

New Institutions and Clinics
Maryland S. 8; New York H. 1607; Texas H. 270; Washington S. 84.

Persons Accused of Crime
Maryland H. 496; New York H. 857.

Sterilization
Illinois H. 251; Missouri H. 290; New York H. 338; Oklahoma H. 422; Texas H. 399; Washington S. 220.

Arkansas

H. 139. Would make two years' confinement in a hospital for mental disease ground for divorce.

S. 65. Would fix the marriageable age of males at eighteen and of females at sixteen, and would require health certificates of both showing that they are not insane, idiots, or suffering from communicable diseases.

Illinois

H. 251. Would provide for the sterilization of inmates of state institutions for the insane, feebleminded, or mentally deficient.

Maine

H. 1543. Would provide for the deportation of alien criminals, paupers, and insane.

Maryland

H. 84. Would make hopeless insanity a ground for divorce.

H. 496. Would require examination of the mental condition of persons indicted for murder by a committee of the board of mental hygiene.

S. 8. Would create and establish, with an appropriation of $100,000, a state training school for feebleminded colored persons.

Michigan

S. J. R. 6. Proposed an amendment to the state constitution authorizing the state to borrow money for the purpose of building hospitals and asylums for the insane and other institutions.

Missouri

H. 290. Would provide for the sexual sterilization of feebleminded, epileptic, and insane persons and habitual criminals.

New York

H. 338. Would provide for sexual sterilization of the insane, feebleminded, and epileptic.

H. 857. Would amend the mental-hygiene law and the code of criminal procedure by creating in the department of mental hygiene a division for the examination of certain persons accused of crime. Summarized in the April number of MENTAL HYGIENE.

H. 1160. Relates to the certification of qualified psychiatrists. Summarized in the April number of MENTAL HYGIENE.

H. 1607. Would create a mental-hygiene clinic in the New York City Court of General Sessions.

H. 1823. Relates to the construction of buildings for the care, support, instruction, and training of wards of the state, state insane hospitals, and charitable institutions.

Oklahoma

H. 422. Would provide for the sexual sterilization of insane and feebleminded patients in state institutions.

Pennsylvania

H. 227. Relates to the protection of insane, feebleminded, and epileptic patients. Summarized in the April number of MENTAL HYGIENE.

Texas

H. 270. Would establish a state tuberculosis and epilepsy sanitarium for Negroes.

H. 399. Would provide for the sterilization of inmates in state institutions for the insane, feebleminded, and epileptic.

U. S. Congress

S. 5602. Would provide for the transfer of insane American citizens in foreign countries to St. Elizabeths Hospital at Washington.

Washington

S. 84. Would establish a state institution for the feebleminded.

S. 136. Would provide for a state board of public welfare.

S. 216. Would create a children's code commission to study child welfare, etc.

S. 220. Would provide for the sexual sterilization "of certain potential parents carrying degenerate hereditary qualities".

The Thomas W. Salmon Memorial

Plans have been perfected for a memorial to the late Dr. Thomas W. Salmon, former professor of psychiatry at Columbia University and Medical Director of The National Committee for Mental Hygiene. These plans call for the creation of an endowment fund of $100,000 or more, the income from which is to be devoted to an annual lecture or series of lectures to be known as The Thomas W. Salmon Memorial Lectures, to be given by authorities in psychiatry and mental hygiene for the purpose of advancing knowledge in these fields.

The administration of the memorial and the custody of the fund will be vested in the New York Academy of Medicine which will coöperate with a special psychiatric committee to be appointed for the purpose of selecting the lecturers, the topics to be presented, and the places where the lectures are to be given. Provision will be made for the publication of the lectures from year to year in leading periodicals and in book form.

The project was launched by a national committee composed of leading psychiatrists, neurologists, psychologists, nurses, social workers, educators, and mental-hygiene workers throughout the country who have undertaken to raise the fund by popular subscription. In its announcement of the plan this committee made the following statement:

"Psychiatry and mental hygiene have never had the benefit of this type of lecture provision which may well be the means of furthering knowledge in an important field and is, at the same time, particularly suited to the aims of the memorial.

"Such lectures will serve as an inspiration and incentive for the production of notable and distinctive contributions to the aims and purposes that were so nobly exemplified in Dr. Salmon's personality and career. They will have the merit of stimulating original work in every sector of the broad field of psychiatry and mental hygiene. They will turn the attention of students to difficult problems now pressing for solution and will encourage investigations and studies that may lead to discoveries of great scientific and social significance.

"Finally, by their publication and distribution from year to year,

these lectures will achieve a value and influence that will extend beyond the lecture hall and be nation-wide in their educational effects. In this way The Thomas W. Salmon Memorial Lectures may readily become an outstanding event of the year in the scientific world.''

The officers of the memorial are as follows: *Honorary Chairman,* Hon. George W. Wickersham; *Honorary Vice-Chairmen,* General John J. Pershing, Dr. Nicholas Murray Butler, Rev. Harry Emerson Fosdick, D.D., Mrs. Helen Hartley Jenkins, and Dr. John H. Finley; *Chairman,* Frankwood E. Williams, M.D.; *Vice-Chairman,* William L. Russell, M.D.; *Secretary,* Austen Fox Riggs, M.D.; *Assistant Secretary,* Paul O. Komora, Esq.; *Treasurer,* The New York Trust Company; and *Assistant Treasurer,* Samuel W. Hamilton, M.D.

Checks should be drawn to The Thomas William Salmon Memorial, Inc., and sent to Dr. Samuel W. Hamilton, Assistant Treasurer, 370 Seventh Avenue, New York, N. Y.

Venereal Disease Among State Prisoners

The following statistics with regard to the incidence of venereal disease among the prisoners at the California State Prison at San Quentin appeared in a recent number of the *Journal of the American Medical Association.* They were contributed by Dr. L. L. Stanley, resident physician at the prison.

Every prisoner who enters San Quentin is given a thorough physical examination, including the Wassermann test for syphilis. During the period from January 1, 1918, to January 1, 1926, 10,000 men were thus examined. Of these men, 8,004, or 80 per cent, were white; 530, or 5.3 per cent, Negroes; 1,265, or 12.65 per cent, Mexicans; and 201, or 2 per cent, yellow.

Positive Wassermann reactions were obtained from 921, or 9.21 per cent of the 10,000. This group was made up of 578, or 7.2 per cent, of the white men; 96, or 18.1 per cent, of the Negroes; 198, or 15.6 per cent, of the Mexicans; and 49, or 24.3 per cent, of the yellow race.

A history of venereal sore which may have been chancre, chancroid, herpes, or venereal wart was obtained in the case of 1,507, or 15 per cent, of the 10,000, while 4,820, or 48.2 per cent, gave a history of gonorrhea that could not well be mistaken.

Of the 10,000 prisoners, 36.58 per cent were married and 63.42 per cent single.

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MENTAL HYGIENE

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THE AMERICAN FOUNDATION FOR MENTAL HYGIENE

ITS ORIGIN, PURPOSES, AND PERSONNEL

THE American Foundation for Mental Hygiene, Incorporated, was created on May 24, 1928, under the laws of the state of Delaware, and later was officially approved by the proper authorities of the state of New York. Its office is at 370 Seventh Avenue, New York City, in the suite of The National Committee for Mental Hygiene, under whose auspices it was established for the purpose of serving as custodian and administrator of gifts and bequests for agencies or work in any part of the field.

The chief purposes of this Foundation are, in effect, virtually the same as those of The National Committee for Mental Hygiene, except that, whereas that organization is an operating agency, the Foundation is to be primarily a financing agency, with no intention of becoming an operating one. In short, the Foundation aims to give financial aid, in so far as its resources permit, to work—including research—which will help to conserve mental health, reduce and prevent nervous and mental disorders and mental defect, and improve the care and treatment of those suffering from these disorders. In the doing of this it will, perforce, aid work that will spread reliable information on these subjects, on mental factors involved in the problems of education, the mental hygiene of childhood, industry, delinquency, crime, dependency, and on other subjects related to the broad field of human behavior.

The need for a special Foundation, devoted exclusively to

the financing of mental-hygiene activities, whose funds shall be administered by a board of trustees composed largely of persons possessed of special and expert knowledge of the subjects dealt with, has been borne in upon those who for the past twenty years have had to struggle, with inadequate and uncertain financial resources, to develop the work of the National Committee and the mental-hygiene movement in general on a scale in keeping with the ever-growing needs and demands.

Now, through a permanent agency such as the Foundation, the financial resources for mental-hygiene work can be pooled and, in course of time, a great fund for the financing of mental-hygiene agencies and activities will be secured by influencing donors to give as liberally for the mental welfare of mankind as they have long been in the habit of doing for the physical welfare of mankind. Heretofore, only a small part of the money given or bequeathed for philanthropic purposes in this country has been given in furtherance of work in behalf of the insane, feebleminded, or epileptic. Relatively little has been donated for research in this field, for the prevention of nervous or mental disorders, or for those constructive measures which, if rightly and widely applied, would add greatly to the sum total of mental health and happiness in the nation through the adjustment of personality difficulties and faulty mental habits among tens of thousands of the general public. This is especially important in the case of the younger generation, many of whom, though they may never require commitment to institutions, are doomed to handicapped lives unless given intelligent and timely guidance along mental-hygiene lines. When the relatives and friends of the mentally afflicted—and any one is mentally afflicted whose mind so functions as to make it impossible or unusually difficult for him to fit into family, social, or business life—learn of the existence and purposes of the Foundation, they will, it is confidently believed, give or bequeath to it at least a fair percentage of their gifts to charitable and public enterprises.

Gifts and bequests may be made for the general purposes of the Foundation, which in the long run is the most effective way to make a gift productive of results, since succeeding boards of trustees can then use the money to meet new needs

as they arise. Or they may be made for specific purposes, such as giving financial aid to national, state, and local agencies or institutions engaged in one phase or another of mental-hygiene work, the idea being that a donor desirous of having a gift or bequest permanently productive will prefer to have the money held and administered by a Foundation of the lasting type described.

The American Foundation for Mental Hygiene, which, as its name implies, belongs to the whole public, in contradistinction to the many funds and Foundations created and financed by one individual or by one family, began its work in May, 1928, with a gift of $50,000, given by the executors of the estate of the late Mrs. Annie C. Kane of New York. Most of this gift has been set aside to underwrite the basic expenses of the First International Congress on Mental Hygiene, to be held in Washington, D. C., May 5th-10th, 1930, of which President Hoover is the honorary president. A special gift of $5,000 is being used to meet general expenses of the Foundation, including the costs connected with its organization and incorporation. A conditional pledge of $100,000 has been secured toward the first million dollars raised, and bequests to the value of more than $600,000 have already been incorporated in wills definitely known about. It is interesting to note that these bequests cover a variety of activities—namely, research, publication, mental-hygiene work in a given state, college mental hygiene, and the general purposes of the Foundation.

The officers of the Foundation are: *Honorary President,* Dr. William H. Welch, former Director of the School of Hygiene at Johns Hopkins University; *President,* Dr. Arthur H. Ruggles, Chairman of the Executive Committee of The National Committee for Mental Hygiene and Medical Director of Butler Hospital, Providence, R. I.; *Vice-Presidents,* Dr. James R. Angell, President of Yale University, New Haven, Conn., Rt. Rev. William Lawrence, D.D., Boston, Mass., Dr. William L. Russell, General Psychiatric Director of Bloomingdale Hospital, White Plains, N. Y.; *Treasurer,* Frederic W. Allen of Lee, Higginson and Company, New York City; *Secretary,* Clifford W. Beers, Founder and Secretary of The National Committee for Mental Hygiene, New York City, and

author of *A Mind That Found Itself*,[1] the publication of which led to the inauguration of the mental-hygiene movement.

In addition to the above officers, the Board of Trustees is as follows: Dr. William A. White, Superintendent of St. Elizabeths Hospital, Washington, D. C.; Dr. C. Floyd Haviland, Superintendent of Manhattan State Hospital, Ward's Island, New York City; Dr. Frankwood E. Williams, Medical Director of The National Committee for Mental Hygiene, New York City; Dr. Bernard Sachs, Neurologist, Mt. Sinai Hospital, New York City; Dr. George L. Wallace, Superintendent, Wrentham State School for the Feebleminded, Wrentham, Mass.; Dr. Charles P. Emerson, Dean of the Indiana University School of Medicine, Indianapolis; Dr. C. Charles Burlingame, former Executive Officer of the Medical Center, New York City; Harry P. Robbins, New York City, a member of the Board of the Central Islip State Hospital; W. Curtis Bok, Attorney-at-law, Philadelphia; Lindley H. Hill, Manager of Penn Terminal Branch of the Corn Exchange Bank and Trust Company, New York City; and Charles A. Stone, Chairman of the Board of Stone and Webster, New York City.

In order that the Foundation may have the benefit of the advice of a larger group than that comprising the Board of Trustees, which, of necessity, must be kept relatively small if it is to function effectively, a group, known as the Council, will be appointed each year by the Trustees. In this way, all important subjects dealt with can be given representation in the Foundation and thus enhance the value of its work.

None of the officers of the Foundation receive remuneration. Furthermore, operating expenses can be kept at a minimum because of its close connection with The National Committee for Mental Hygiene, members of whose staff can be called upon for special services when and as required.

There seems no more appropriate way to conclude this statement than to quote the Preamble to the Certificate of Incorporation of the Foundation which was written by Mr. W. Curtis Bok, who prepared the articles of incorporation:

[1] Published by Doubleday, Doran and Company, Garden City, N. Y., the 15th printing of the book having been issued in May, 1929.

PREAMBLE

We, the founders of The American Foundation for Mental Hygiene, are met upon the effort to create and carry forward a means effective to the end of promoting and conserving mental health and ameliorating the scourge of mental ill health.

Science takes exception to the law that only those whom nature deems the fittest shall survive. Nature has her hidden remedies for the torture of a broken mind or body, and science is upon the march in search of those remedies, that they may be rededicated to mankind. The knowledge so gained forms a sacred trust of civilization for the maintenance of the strong, for the refitting of the weak and sick to their health and opportunity, and for their deliverance to a useful life in the community and that pursuit of happiness which is the proper promise of creation.

In such trusteeship it is our faith that this Foundation will take its place.

PREDICTABILITY IN THE ADMINISTRATION OF CRIMINAL JUSTICE *

SHELDON GLUECK, PH.D., LL.M.
Assistant Professor of Criminology, Harvard Law School
ELEANOR T. GLUECK, ED.D.
Research Assistant, Harvard Survey of Criminal Justice

FOREWORD

ROSCOE POUND

NOT the least interesting of present-day movements in jurisprudence is the renewed quest for certainty after the reaction from the formal certainty of nineteenth-century law. In the last century we had looked at the general security from the standpoint of security against the arbitrary action of magistrates and abuse of prosecuting machinery by officials, rather than from the standpoint of security of society against the conduct of offenders. In effect we had sought to put the social interest in the individual life in terms of the general security. It is the task of the criminal law to discover and mark out the lines of a wise adjustment or practical compromise between the general security and the individual life. In the humanitarian thinking of the eighteenth century, stress was put upon the individual life, and until recently that interest in effect had preponderant recognition. The whole apparatus of criminal justice was shaped by the quest for means of insuring an abstractly uniform, outwardly mechanical administration. The superseding of the common-law principle as to misdemeanors by a doctrine of *nulla poena sine lege,* minutely defined degrees of crime, and exact statutory penalties, worked out in detail for minutely differentiated offenses, tied tribunals down rigidly in appearance, while all sorts of mitigating devices, parallel with them and running through the whole course of a prosecution, tempered them in action.

Inevitably there was a reaction from the futile, cast-iron,

* Reprinted from the *Harvard Law Review*, January, 1929.

prescribed penal treatment characteristic of the last century. A movement for individualization on every side of the law took in criminal justice the form of a development of individualized penal treatment which was to make the penal treatment fit the criminal rather than the punishment fit the crime. But this movement for individualization and for preventive justice has itself brought about a reaction. On the one hand, it has seemed to threaten the general security. Men have come to fear that in our zeal to secure the individual life we may relax the hold of society upon the antisocial, impair the fear of the legal order as a deterrent upon antisocial conduct, and release habitual offenders prematurely to resume their warfare upon society. On the other hand, it has seemed to threaten the security of the individual life by committing too much to the discretion of administrative officers.

At the moment, reaction from administrative justice, the chief agency of individualization, and from the modes of thought and procedures that it involves, is to be seen in every field of the law. Everywhere we are seeking a real certainty as distinguished from the illusory certainty of the nineteenth century. In juristic thinking there is the revived analytical jurisprudence which, starting from fixed assumptions, is to proceed with mathematical assurance. In Continental Europe there is the "pure science of law" which seeks to give "clarity and rigor" to the phenomena of the legal order by excluding all interpretation and application. In criminal law there is the positivist movement with its reliance upon research and observation and scientific formulation. Bergson taught us the relation of "instinct" to administrative action. He showed us that there are things that can be done only through the trained habits of experienced administrators. Yet their instinct may be guided toward more assured results by formulas scientifically worked out on the basis of exact observation. As the emphasis yesterday was upon this trained instinct, the emphasis to-day is upon the means of guiding it and upon research as a forerunner thereof.

This study by Dr. and Mrs. Glueck comes at an opportune time. When, fifty years ago, Massachusetts enacted the original probation law, the first stone of the edifice of preventive justice was well laid. In the present century for a time

there was a rapid development which has set penal legislation and administration in a direction it must keep for a long time to come. But over-enthusiasm in the decades of progressivism, inadequate provision for administration of the new devices, the necessarily experimental character of some of them, leaving many things to be worked out by trial and error, and the strain put upon the whole machinery of criminal justice by post-war conditions in our large cities, have brought all the agencies of preventive criminal justice under suspicion. Study of the means of insuring that the results of probation and kindred devices of individualized penal treatment may be made reasonably predictable is not merely in the right line of legal thought of to-day; it is needed to save for us one of the really epoch-making discoveries of American legal history. Let it once be made clear that probation laws may be administered with a reasonable assurance of distinguishing between the sheep and the goats, let it be shown that the illusory certainty of the old system may be replaced by a régime of reasonably predictable results as compared with one of merely predictable sentence, and the paths of a modern penal treatment will be made straight. I venture to think that Dr. and Mrs. Glueck have made a noteworthy step in this direction.

INTRODUCTION *

WORKERS in the fields of criminology and penology, as well as far-sighted lawyers and judges, have occasionally conceived of the need for some prognostic instrument whereby they might be enabled to predict with reasonable certainty the future history of various types of criminal offenders.[1] The probable value of such a device cannot be sufficiently emphasized. It would make the process of criminal justice articulate. It would compel judges to think in terms of the future results of the dispositions they make of the cases

* This article is the substance of one chapter of a work of the authors soon to be published by Alfred A. Knopf and Company, under the title, *Five Hundred Criminal Careers.*

[1] So far as we have been able to ascertain, Hornell Hart was the first person to suggest the possibility of adapting to penology the methods used in the insurance field for predictability. See "Predicting Parole Success", by Hornell Hart. *Journal of Criminal Law and Criminology*, Vol. 14, pp. 405–13, November, 1923.

before them for sentence. It would furnish some objective, scientific guide for their sentencing function. Such an instrument would, for example, enable judges to decide, with much more wisdom than is manifest to-day, what types of criminals might be expected to do well on probation, which offenders are more suited to different forms of institutional control, and how to deal with various types of recidivists.

A prognostic device would likewise prove of great value to a parole board in determining in a specific case whether a prisoner should be released on parole—that is, whether, according to past experience with similar cases, he will probably do well on parole and thereafter. Practically, it would aid such a board in deciding whether a prisoner should be paroled for an entirely indeterminate period or only for a brief span sufficient to bridge the gap between the penal institution and unsupervised freedom. It would, moreover, be of value in determining the type of parole supervision best adapted for certain cases.

In addition, such an instrument of predictability would be of great value to social workers and forward-looking legislators in establishing beyond cavil the actual value of existing punitive or reformatory institutions and devices, and in suggesting practical needs and modifications. Finally, a prognostic device scientifically conceived and executed would be extremely useful in the study of crime causation and in suggesting needed experimentation with new correctional methods.

Can such an instrument be devised?[1] If so, how would it

[1] See "Workings of the Indeterminate-Sentence Law and the Parole System in Illinois", by Andrew A. Bruce, Ernest W. Burgess, Albert J. Harno, and John Landesco. *Journal of Criminal Law and Criminology*, Vol. 19, No. 1, Part II, pp. 30–306, May, 1928, Chapter XXX. Professor Burgess attempts to answer the question, Can scientific methods be applied to parole administration? He presents a table of "expectancy rates of parole violation and non-violation". There are, however, a number of fundamental weaknesses in his device: (1) While the report of the committee does not clearly indicate just how the social and criminal data on which the device is based were gathered, verified, and augmented, there appears a confession in the report that makes one wish that the raw material of that research were more reliable: "Were the record more accurate, it is certain that higher correlations between various factors making for success or failure while on parole would be secured." (*Op. cit.*, p. 264.). (2) In constructing his expectancy-rate table, Professor Burgess apparently gives *equal weight* to all the factors concerned with "success" or "failure" of the

actually be utilized by judges and parole boards? Would it be really practicable? Answers to these questions are attempted in the following pages.

RESEARCH UPON WHICH PROGNOSTIC TABLES ARE BASED

In order to grasp fully the significance of the prognostic device that will be offered, a brief description of the foundation upon which it rests and the method followed in its construction is necessary. A careful study of existing annual reports, results of surveys, and systematic "criminologies" must convince the experienced student in this field that there has heretofore never been any thorough check-up of the work of a penal institution by means of a careful tracing of the parole and post-parole histories of its former inmates. In general it may be said that the existing materials suffer from two very serious defects. To begin with, the statements as to social data found in official sources, as well as in the criminal records, have ordinarily been neither verified nor amplified. This largely accounts for the claims made in the annual reports of reformatories that from 65 per cent to 85 per cent of their former inmates have "reformed".[1] Another grave

offender on parole. He himself elsewhere shows, however, that the twenty-one factors he uses for his expectancy-rate table are not all of equal influence. (*Op. cit.*, Chap. XXVIII.) (3) The research mentioned does not study the behavior of the ex-prisoners during a *post-parole* period. It is one thing for a man to behave satisfactorily while under parole supervision and another for him to continue so for a reasonable period after such control has been removed. (4) It is not shown how the expectancy-rate table would actually work. Presenting "violation rates" (on parole only, not thereafter) for two illustrative cases, Professor Burgess arrives at the conclusion that "Case A will not succeed on parole, while Case B is a very good risk". (*Op. cit.*, p. 246.) But how much of a risk B is, or just what the mathematical probabilities are of A not succeeding on parole are not indicated. (5) No prognostic devices are furnished for the use of courts, nor is their value recognized. In spite of these almost fatal defects, Professor Burgess must be credited with having made a beginning in this important field and having been among the first to recognize its possibilities.

[1] As quite typical of the claims made, the following may be cited: The Elmira (New York reformatory) "institution is doing a remarkable piece of work in training such boys so that only one-third of them again come in contact with the law". (*Criminology and Penology*, by John Lewis Gillin. New York: The Century Company, 1926. p. 636.) Some of the early Elmira reports claim that 85 per cent of their graduates have "probably reformed". Clark found "that an average of 72 per cent of paroles of nineteen institutions of various kinds are successes". (See "Success Records of Prisoners and Delinquents", by Willis W. Clark. *Journal of Delinquency*, Vol. 6, pp. 443–452, July, 1921.) Clark averaged the figures in annual reports and in a few superficial local investiga-

defect is that no allowance has been made for a post-parole period. An examination of the conduct of former parolees during a reasonable period following the end of their supervision on parole is indispensable if one would establish the probable permanence of their reform or ascertain a return to criminality. We have found that good conduct on parole is not necessarily predictive of good conduct thereafter.

In the investigation upon which this article is based, every reasonable effort has been made to eliminate weaknesses of the kind mentioned. In response to the need for a reliable audit of the work of penal institutions, a follow-up investigation was begun in September, 1925,[1] of all former inmates of the Massachusetts reformatory whose parole periods expired

tions with regard to "successes" of parolees of institutions ranging from schools for delinquent children to penitentiaries for hardened criminals, in spite of the fact that the reports vary in reliability and thoroughness and that the inmates of institutions of course differ in many ways. Since the claims made in annual reports are to a large extent unfounded or not disinterested, his conclusions cannot be accepted. R. H. Gault, in an ingenious analysis, based his conclusions on the alleged parole history of over 38,000 parolees. But the information was "secured . . . by correspondence with state officials and by consulting the most recent state reports". No wonder he found that 84 per cent of the parolees "made good", concluded optimistically that "it seems safe to say . . . that 80 per cent of men paroled fulfill the conditions", and leaped to the *non sequitur*—"and become law-abiding citizens"! (See "The Parole System, A Means of Protection", by Robert H. Gault. *Journal of Criminal Law and Criminology*, Vol. 5, pp. 799–806, March, 1915.) In the research upon which this article is based, we found that a painstaking check-up discloses that only *20 per cent* of the graduates of one of the better American reformatories have abandoned their life of crime.

This paucity of reliable facts on the actual efficacy of peno-correctional institutions exists with reference to courts (juvenile and adult) and probation, as well as to prisons and reformatories. Misinformation, founded on superficial research, is of course worse than no information.

[1] A grant for this purpose was made to Dr. Richard C. Cabot, Chairman of the Department of Social Ethics of Harvard University, by the Milton Fund of the university. The work was begun in September, 1925, and carried on over a period of three academic years. The authors desire to take this opportunity to thank Doctor Cabot, not only for obtaining the funds needed for the investigation, but for the constructive aid, advice, and encouragement he gave throughout; and also to acknowledge their indebtedness to the Milton Fund of Harvard University. They further desire to thank Hon. Sanford Bates, formerly Commissioner of Correction, Massachusetts, without whose hearty and enthusiastic coöperation it would have been impossible to carry out the investigation. Our thanks are also due to Superintendent Charles T. Judge, Dr. Guy G. Fernald, and other members of the staff of the Massachusetts Reformatory for their cheerful, active coöperation throughout the research. We are also under deep obligation to Professor E. B. Wilson and Professor Ernest Hooton, of Harvard University, for statistical advice and general encouragement.

during the years 1921 or 1922. They comprised a total of 510 cases. By the method of selection and by comparison with the characteristics of inmates of other years, it was established that the 510 men studied are typical of the general "run of the mill" in the Massachusetts institution. Since, however, existing annual reports of other reformatories are for various reasons not absolutely comparable with our own data, it is impossible to state definitely that the 510 men studied are typical also of that vast camaraderie of crime that annually passes through the young men's reformatories throughout the country. But if similarity of age distribution, occupation, extent and nature of criminality preceding sentence to the reformatory, and other factors are taken as indices, one may hazard the opinion that our 510 young men are quite typical of the inmates of adult reformatories in other states. Another advantage of the method of selection used was that it enabled up to allow each man the same length of time, a five-year post-parole period, during which his unsupervised conduct was recorded and might be studied.

Numerous difficulties must be overcome before an investigation of the type outlined can be successfully completed, and this probably is one of the reasons why such a study was never made before. Special techniques of search and research had to be evolved to meet these difficulties. The first barrier encountered was that of locating the men five years after the expiration of their parole periods. Only when one takes into account the poor condition of American systems of criminal identification, the easy passage of offenders across state boundaries, and the great mobility of young-adult criminals, do the true proportions of the task become apparent. Nevertheless, fully 90 per cent of the ex-prisoners were located, many in Massachusetts and throughout the United States and a few in Europe, China, and Australia, at a time five years beyond the expiration of their parole periods and from six to ten years after their discharge from the reformatory on parole.[1]

The deplorable condition of existing official records as to social and psychiatric data constituted the second great obstacle. Concerning this difficulty, it can only be said that

[1] It is obviously impossible in an article to render account of the methods that had to be devised for this purpose. In their forthcoming book, the authors elaborate these in great detail, for use in further researches.

all source materials relating to social data had to be carefully supplemented and verified. This work required the mailing of many thousands of letters and questionnaires, the consultation of a great variety of records, the use of numerous copies of existing fingerprints, and, finally, the interviewing of hundreds of persons, including some 200 of the 510 ex-inmates under consideration.

The work of investigation, the statistical schedules, and the computations upon which the prognostic tables presented below are based, were in general divided into four sections: (1) the history of the youths prior to their sentence to the reformatory, including certain facts about their family background; (2) the history of the men while they were in the institution; (3) their history while on parole; and (4) their post-parole history, which embraced not only their criminal conduct, but also their industrial activities, family life, economic history, use of leisure, habits, and other significant items during the five-year period following the expiration of parole. More than fifty factors[1] concerning the careers of

[1] *Pre-reformatory factors:* Education of parents, family delinquency, economic status of parents, nativity of parents; nativity of prisoner, his mobility, religion, church attendance, use of leisure and habits; age of leaving home, cause of leaving home; age he began to work, degree of industrial skill, work habits, economic responsibility; moral attitude toward his family; the age of his first known delinquency, seriousness of his criminality prior to the commission of the offense for which he was sentenced to the reformatory, frequency of pre-reformatory arrest, time spent in penal institutions prior to the reformatory sentence, offense for which he was sentenced to the reformatory, whether he committed the offense alone or in company of others; his age upon entering the reformatory, his physical condition, intelligence grade, mental condition from a psychiatric point of view. *Reformatory factors:* The number of different occupational experiences the prisoner was given in the reformatory, the kind of worker he was therein adjudged to be by the instructors in charge of shops and trade school; the nature and frequency of his misconduct in the institution, the length of time he spent therein. *Parole factors:* Conduct of the ex-prisoner during parole, the length of time he was on parole, the nature and extent of the supervision he received while on parole. *Post-parole factors:* Criminal conduct of the ex-parolee during the five-year post-parole test period; use or non-use of the occupations taught at the reformatory, work habits, industrial skill; economic status, economic responsibility toward family; marital status, attitude toward family; type of home, type of neighborhood; use of leisure and habits, mobility, church attendance.

It is obviously impossible to present herein the sub-categories of these many factors or to give any definitions of the terms, except in cases where they are deemed indispensable. It may be stated, however, that we defined each term with care and in detail, after consultation with various authorities, so that there could be no possible misunderstanding of its usage.

this group, from childhood through the post-parole period, were studied. By means of correlation tables and a suitable statistical device, the relation between each of these factors and the status of the men as to *post-parole* criminality was established. The exact process by which this was accomplished may best be illustrated by the two following tables, the first of which shows the relation between the seriousness of the offense for which the men were originally committed, and their post-parole status from the point of view of criminality.

TABLE I.—SERIOUSNESS OF OFFENSE FOR WHICH SENTENCE TO MASSACHUSETTS REFORMATORY WAS IMPOSED RELATED TO CRIMINALITY DURING FIVE-YEAR POST-PAROLE PERIOD.

Seriousness of offense for which original sentence was imposed	*Criminal conduct record during post-parole period*			
	Percentage of successes	Percentage of partial failures	Percentage of total failures	Total percentage
Major	21.7	17.5	60.8	100
Minor	25.0	18.7	56.3	100
Total	22.1	17.7	60.2	100

Coefficient of contingency .05

The table indicates that there is but a negligible relationship between the seriousness of the offenses for which the men were originally sentenced to the reformatory and their criminal activity after the expiration of the parole period.[1]

[1] The status of the men as regards their criminal conduct during the five-year post-parole period was determined according to the following criteria:

Success: No police or court record, except occasional technical automobile violations; no dishonorable discharge or desertion from army or navy; no commission of individual criminal acts, even though no arrest or prosecution was made.

Partial failure: Conviction on two minor offenses (see note 1, page 687, for distinction between major and minor offenses), or arrest for not more than three minor offenses not followed by conviction. In the case of technical automobile offenses or drunkenness, we had planned to allow as many as five arrests for the partial-failure class. There was not one case, however, in which assignment to a particular category depended solely upon an automobile or drunkenness record; there were always other types of offense also involved. Partial failure was also assigned to cases in which there had been arrests for not more than two serious offenses not followed by conviction; or arrest for one serious offense not followed by conviction and for not over two minor offenses not followed by conviction, or occasional minor offenses for which the violator of the law was neither arrested nor prosecuted (*i.e.*, cases of sporadic, rather than continuous, misconduct definitely known to have occurred, but as to which no official action was for various reasons taken). Only four cases were assigned to this category on the basis of arrests not followed by convictions.

Those who were originally committed for major offenses.[1] have but a slightly lower percentage of post-parole successes, and a slightly higher percentage of total failures, than either those sentenced for minor offenses or all the cases regardless of seriousness of offense. The negligible bearing of the seri-

Total failure: Cases in which there had been arrests for three or more serious offenses, not followed by conviction, or arrests for more than three minor offenses (except drunkenness) not followed by conviction (actually, there were no such instances); or convictions for one or more serious offenses; or convictions for more than five charges of drunkenness (comprising only a few cases); or desertion or dishonorable discharge from army or navy; or the status of fugitive from justice or being wanted for escape; or known commission of serious offenses, or a continuous course of minor offenses for which the men were somehow not arrested or prosecuted.

[1] Division of crimes into major and minor (serious and less serious) offenses is based largely on the statutory distinction as indicated by jurisdiction of the superior and municipal (or district) courts, respectively, and by the possible maximum punishments. These principles express society's estimate of the relative social harmfulness of different crimes taken as isolated acts and therefore are legitimately utilizable for the purpose indicated in note 1, page 686. To the above two principles there has occasionally been added our judgment of the relative social harmfulness of different offenses considered as isolated acts. That there is room for some difference of opinion as to the relative social harmfulness of different offenses is indicated by the wide divergence in the statutory punishments for the same acts in the various states. This is a fact that every system of classification of isolated acts, *rather than persons,* must face. The following classification was used for the purpose mentioned:

I. Major offenses: A. Property crimes: 1. Burglary and possessing burglar's tools. 2. Larceny; receiving stolen goods. 3. Robbery, including assault with intent to commit robbery, and attempt to commit robbery, as well as the possession of weapons when the circumstances indicated they were directly intended to be used for robbery; where this was doubtful, possessing weapons was classified under minor offenses. 4. Arson. 5. Crimes usually (not always) involving or implying higher intelligence, *e.g.,* embezzlement, obtaining property under false pretenses, etc. *B.* Sex offenses: 1. Violent and deliberate, sexually-motivated attacks (rape). 2. Pathological sex expressions (homosexuality, incest). *C.* Other serious crimes: 1. Homicide, including a few attempts to commit murder or suicide. 2. Escape or rescue. 3. Being a fugitive from justice. 4. Dishonorable discharge or desertion from army or navy. 5. Serious auto violations, as driving away from scene of accident, etc.

II. Minor offenses: A. Offenses involving habit-forming drugs or stimulants (including drunkenness, violation of liquor law, possessing or dealing in drugs). *B.* Vagrancy, begging, living on proceeds of prostitution. *C.* Sex offenses (adultery, lewd and lascivious cohabitation, accosting female, fornication). *D.* Offenses involving domestic relations (non-support, desertion, bastardy, cruelty to children, etc.). *E.* Simple assaults (all assault and battery, except with intent to kill, rape, or rob). *F.* Disturbing the peace. *G.* Malicious mischief. *H.* Offenses involving violation of auto regulations (technical). *I.* Other offenses (peddling without license, contempt, violation of police regulations, etc.).

ousness of the crime for which sentence to the reformatory was imposed on what the ex-prisoners will do during the post-parole period is also indicated by the low coefficient of contingency. This coefficient is a mathematical device for indicating the relationships shown in the table by means of a single convenient figure.[1] It is mathematically possible in a twofold table for the coefficient to be as high as .71 and in a threefold table for it to be .82. Such high coefficients would result if there were a practically perfect relationship between the two items—seriousness of offense for which original sentence was imposed and post-parole criminal conduct. That the coefficient is, however, only .05 is a reflection of the fact that the two items mentioned are hardly at all related.

A second illustration of the manner in which each of the fifty factors in the lives of our 510 ex-prisoners was related to the criminal behavior of the men during the five-year post-parole period is furnished by Table II. This indicates the relationship between the industrial habits[2] of our ex-prisoners prior to their sentence to the reformatory, and their criminal conduct during the post-parole period.

[1] For the mathematical theory and process involved in ascertaining the coefficient of contingency, see *An Introduction to the Theory of Statistics*, by George Udny Yule. (Philadelphia: J. B. Lippincott Company, 1922. pp. 65–67.) As will be seen below, only factors bearing a significantly high relationship to post-parole criminality have been utilized in the construction of the prognostic tables. This does not mean that factors of a somewhat lower degree of association are without prognostic worth. But since a high degree of predictability can be obtained in a device constructed of relatively few factors, there is no good reason for using many and thus greatly complicating the prognostic instrument. In considering individual cases, the judge and parole board should, of course, take into account the incidence of other factors shown to be significant for the purpose of prediction, in addition to those actually embraced in the probability tables.

[2] *Good worker:* Reliable, steady, industrious; showing promise of continuing in regular employment; commended by employers. *Fair worker:* A person who has the qualifications of the regular worker, but who permits his work to be interrupted by periodic drinking, the drug habit, occasional vagabondage, stealing, or by deliberate choice of irregular occupations such as longshoring, for the chief purpose of having leisure time. *Poor worker:* One who is not reliable, loafs, is lazy, dishonest, unstable, a vagabond, wayward. These factors were considered independently of the nature of the employment (except where support was derived through proceeds of prostitution or other illegitimate occupations) or seasonal or other fluctuations in industry; and express the man's general disposition toward work. The judgments are based upon the combined opinions of employers, police, and relatives, the last being given the least weight. Thus a *poor worker* is one who, in the long run, constitutes a liability to the employer.

TABLE II.—PRE-REFORMATORY INDUSTRIAL HABITS RELATED TO POST-PAROLE CRIMINALITY

Pre-reformatory industrial habits	*Criminal conduct record during post-parole period*			
	Percentage of successes	Percentage of partial failures	Percentage of total failures	Total percentage
Good worker.....	46.7	10.0	43.3	100
Fair worker.....	20.3	20.3	59.4	100
Poor worker.....	12.1	19.4	68.5	100
Total.....	21.5	17.7	60.8	100

Coefficient of contingency .42

The difference in results obtained here and in the first table is striking, and indicates the importance of the method employed for determining which of numerous factors have the greatest relationship to the conduct of the men once they are released from parole supervision. The seriousness of the crime for which the men were sentenced to the reformatory was in the prior table shown to have little if anything to do with their post-parole conduct. The pre-reformatory industrial habits of the men, on the contrary, obviously are related to their post-parole criminal conduct to a considerable degree. Thus, out of the total number of men involved, 21.5 per cent, or about a fifth, were successful in that they had committed no offenses during the post-parole period. But of those whose pre-reformatory industrial habits had been good, almost half, 46.7 per cent, were successful, while of those whose prior industrial habits had been poor, only 12.1 per cent were successful. Again, 60.8 per cent of the total number of men involved in the table were classified as total failures on the basis of their post-parole criminal conduct. Yet the men who had been good workers prior to their sentence to the reformatory contributed only 43.3 per cent of their number to the total-failure class, while those who had been poor workers contributed 68.5 per cent thereto. The high association between the two items now under discussion—pre-reformatory industrial habits and post-parole criminality—is also shown by the significant coefficient of .42.

By the foregoing method the relationship to post-parole criminal conduct of each of over fifty factors as to which reliable information could be obtained was established. In

this way it became evident that certain factors had little or no association with the men's behavior during the post-parole period, while others varied in importance from those having a slight to those having a very great association. But the establishing of this fact, while important in itself, did not yet furnish the desired instruments to be used in the work of courts and parole boards. The succeeding steps in the necessary process will now be described.

PROGNOSTIC TABLES

The six pre-reformatory factors found by the foregoing method to bear the highest relationship to the post-parole conduct of the men were utilized in constructing the first prognostic table. The procedure was as follows:

First, the actual percentages of the total failures (from the point of view of post-parole criminal conduct) were set down for each of the sub-classes of the six significant factors:

1. Industrial habits preceding sentence to the reformatory.

(Coefficient .42)

Class	*Percentage of total failures*
Good worker	43
Fair worker	59
Poor worker	68

This means that only 43 per cent of those offenders who, during their pre-reformatory life, could be rated as *good workers* turned out to be total failures, as judged by their post-parole criminal conduct. Those who were *fair workers* contributed 59 per cent of their number to the post-parole failures; and those who were *poor workers* contributed 68 per cent of their number to post-parole total failures.

Each of the following factors which were used in the composition of the prognostic tables as described below might be similarly analyzed and interpreted. In all of these groups of sub-classes the size of the coefficient indicates the degree of relationship between the factor as a whole and the conduct of the men during the five-year period following their discharge from parole supervision.

2. Seriousness and frequency of pre-reformatory crime.[1]

(Coefficient .36)

Class	*Percentage of total failures*
Serious offender	67
Frequent minor offender	53
Occasional minor offender	35
Non-offender	21

3. Arrest for crimes preceding the offense for which sentence to reformatory was was imposed.

(Coefficient .29)

Class	*Percentage of total failures*
Those with prior arrests	69
Those without prior arrests	32

4. Penal experience preceding reformatory incarceration.

(Coefficient .29)

Class	*Percentage of total failures*
Those with prior penal experience	74
Those without prior penal experience	47

5. Economic responsibility[2] preceding sentence to reformatory.

(Coefficient .27)

Class	*Percentage of total failures*
Economically responsible	41
Economically irresponsible	64

[1] See notes, pages 686 and 687. Since the pre-reformatory and parole periods were not of the same length as the five-year post-parole period, the time element entered to complicate the classification. This factor was taken account of by translating the number of offenses into frequencies depending upon the time span involved. For example, "arrests for not more than three minor offenses not followed by conviction" (see note, page 686) means the same as arrests for minor offenses on an average of once in twenty months (obtained by dividing the number of arrests into the sixty-month post-parole period). Hence, in classifying a man's conduct during the *parole period*, for example, if an arrest for a minor offense occurred on an average of once in twenty months *based on the actual length of his parole period*, he was counted a partial failure as regards parole criminality. In the case of serious offenses, however, conviction for one serious offense was enough to place a man in the total-failure class regardless of the time element. The object of using the time element was to differentiate between occasional minor offenders and frequent minor offenders as opposed to serious offenders.

[2] *Economically responsible:* contributing toward his own support and toward the support of his parents if such aid was needed; if married, supporting his family. *Economically irresponsible:* not contributing; being a burden on parents; making no effort even partially to support self or family if married. This factor does not take into consideration the extent of self-support or contribution toward family income, but pertains rather toward the youth's disposition to meet his economic responsibilities.

6. Mental abnormality on entrance to reformatory.

(Coefficient .26)

Class	*Percentage of total failures*
None	60
Psychopathic personality	75
Psychotic	87

These factors furnished the basis for the construction of the specialized tables for use by judges in certain situations illustrated below. For the prognostic instrument to be utilized by parole boards in considering applications for parole, the conduct records of the prisoners while in the reformatory had to be taken into account. Other items might also have been used in this connection, but by employing the association tables and coefficients described above they were found to bear but a slight relationship to the post-parole behavior of our men. The following factor, on the other hand, was shown to be considerably related to the post-parole criminality of the men.

7. Frequency of offenses in the reformatory.

(Coefficient .33)

Class	*Percentage of total failures*
One offense in four months or less	70
One offense in more than four months, or no offenses	30

For the prognostic device to be used by parole boards in continuing supervision or in changing the form of treatment, the conduct record of the men while on parole had to be taken into account. Other parole factors were as before disregarded for this purpose because shown to bear but a negligible relationship to the post-parole conduct of the men.

8. Criminal conduct during parole.

(Coefficient .47)

Class	*Percentage of total failures*
Successes on parole [1]	30
Partial failures on parole	31
Total failures on parole	77

Finally, for the prognostic instruments to be used by judges in dealing with recidivists—that is, men who, having already passed through the existing reformatory and parole régimes, again commit crimes—the five highest post-parole factors were added to the foregoing, as follows:

[1] See notes, pages 686 and 687, and note 1, page 691.

9. Industrial habits[1] following expiration of parole.
(Coefficient .59)

Class	*Percentage of total failures*
Good worker	19
Fair worker	66
Poor worker	92

10. Attitude toward family[2] following parole.
(Coefficient .58)

Class	*Percentage of total failures*
Good	10
Fair	50
Poor	85

11. Economic responsibility[3] following parole.
(Coefficient .53)

Class	*Percentage of total failures*
Good	6
Fair	53
Poor	85

12. Type of home[4] following parole.
(Coefficient .48)

Class	*Percentage of total failures*
Favorable	24
Fair	44
Unfavorable	86

13. Use of leisure[5] following parole.
(Coefficient .46)

Class	*Percentage of total failures*
Constructive	0
Negative	15
Harmful	81

[1] See note 2, page 688.

[2] If a man met the following standard, his attitude toward family was designated as *fair:* Not known to be harming his family in any way deemed injurious to the institution of the family. If married, not known to neglect or desert wife or children; not separated or divorced from wife, not having illicit relations with other women; not abusive to wife or children; not away evenings continually. If he failed to meet this standard, he was classed as *poor.* If the family relationships were particularly good and constructive, he was assigned the grade *good.*

[3] *Good:* Comfortably supporting self and dependents if single, or wife if married. *Fair:* Supporting self or dependents marginally—*i.e.,* without more than occasional public or private aid, including occasional assistance from relatives when man should be self-supportng. *Poor:* Failing to support self or dependents or contracting avoidable debts, or receiving frequent aid from welfare agencies or from family, when he should be self-supporting.

[4] *Favorable:* Comfortable apartment, roomy and well-furnished. *Fair:* Not too crowded, clean, decent furniture. *Unfavorable:* Overcrowded, dark, dirty, scantily furnished.

[5] *Constructive:* Is a member of well-supervised social group, such as Y. M. C. A. or K. of C.; is utilizing leisure time to further himself educationally, as by attending night high school, or vocationally; has no bad habits of the kind in-

So much for the second step in the process of constructing predictability tables. The *third* step consisted in determining the highest score, on the one hand, and the lowest, on the other, that it was possible for a person to have on the basis of the foregoing percentages. This was done by adding up all the lowest percentages listed above, which gave the lowest possible total-failure score, and then adding up the highest percentages, which yielded the highest possible total-failure score. Score classes between these two limits were then established experimentally, and each of the men involved was classified therein according to his particular score and his criminal class. The numbers in each class were then converted into percentages. The following table, which is based on the first six factors, will indicate how this was done.

TABLE III.—PROBABLE PERCENTAGES OF POST-PAROLE SUCCESSES, PARTIAL FAILURES, AND TOTAL FAILURES FROM THE STANDPOINT OF CRIMINALITY, BASED ON SCORES ON SIX MOST IMPORTANT PRE-REFORMATORY FACTORS

	Probable status as to post-parole criminality			
Total-failure score	Percentage of successes	Percentage of partial failures	Percentage of total failures	Total percentage
244–295	75.0	20.0	5.0	100
296–345	34.6	11.5	53.9	100
346–395	26.2	19.1	54.7	100
396 and over	5.7	13.7	80.6	100
Total	20.0	15.6	64.4	100

Coefficient of contingency .45

From this table a judge, considering whether or not to sentence an offender to the reformatory, can with considerable accuracy determine the advisability of such disposition of the case before him, provided he has reliable information as to the offender's status on the six factors upon which the table is based. Thus a prisoner who scores as low as 244 to 295 on

dulged in by the harmful group. *Negative:* At least not engaging in harmful activities, though not using leisure time constructively; no bad habits of the kind mentioned below, but occasional gambling, such as "shooting craps" or playing cards at home. Mild occasional drinking, rarely or never resulting in intoxication, was allowed for. There are also included in this group those who spent their leisure wholesomely with their families or friends. *Harmful:* Pronounced bad habits, associates; recreation which may lead to criminal conduct, such as going about with bad companions, membership in gangs; being addicted to drugs, excessive drinking or gambling; sex vices. The presence of any one or combinations of these factors placed the men in this group. In hardly a single case, however, did these vicious habits exist alone; the rule was rather the massing of vices.

these six pre-reformatory factors has seven and a half in ten chances (75:100) of being a success in post-parole conduct, while one with as high a failure score as 396 or over has but half a chance in ten (5.7:100) of succeeding. The first man also has two in ten chances (20:100) of failing only partially, and only half a chance in ten (5:100) of being a complete failure; the second has but one chance in ten (13.7:100) of failing partially and eight out of ten chances (80.6:100) of turning out to be a complete failure.

In presenting the above illustration of a possible prognostic device to aid the courts, it should be added that we do not propose the immediate adoption of the failure and success rates above given. It is the idea and the method of prognosis in this field that concerns us, rather than the construction of a failure-rate prognostic table that might be used in the courts of Massachusetts or elsewhere to-morrow.[1] It will be valuable to test the extent of reliability of such tables by constructing them on the basis of another sample of offenders and comparing the results with those obtained herein. Moreover, it should be pointed out that the probable failure rates given in the tables are based on the Massachusetts reformatory and parole systems essentially as they are at present and not as they might be. They would probably need to be considerably modified in the light of experience with improved machinery of rehabilitation.

The next prognostic table is presented as a possible model for parole boards in determining which men to release on parole, and in obtaining some true conception of the probable length of parole supervision needed in different cases. For

[1] The method used in the construction of the prognostic instrument herein presented is the simplest, mathematically, that we could devise. It yields as good results empirically as a much more elaborate statistical procedure which we employed and abandoned in favor of the above. The more involved statistical method consisted of (1) computing, as to each sub-class of each factor, the differences between the actual frequencies of failure and the "independence frequencies" (that is, the mathematically expected frequencies); (2) ascertaining the percentage that these differences were of the total cases in each sub-class; and (3) distributing the cases into failure-score classes on the basis of such derived percentages rather than the actual percentages of failure utilized above. Upon the advice of Professor E. G. Wilson and Professor Ernest Hooton, the simpler method was adopted when it was ascertained that it gave results essentially similar to those derived by the much more complex statistical procedure.

this purpose, not only the six highest pre-reformatory factors have been used, but that factor of the reformatory period which was found to be related higher than any other to post-parole criminality—namely, the frequency of misconduct of the men in the reformatory.

TABLE IV.—PROBABLE POST-PAROLE CRIMINALITY RATES BASED ON TOTAL FAILURE SCORES ON SIX HIGHEST PRE-REFORMATORY FACTORS AND HIGHEST REFORMATORY FACTOR

	Probable status as to post-parole criminality			
Total-failure score	Percentage of successes	Percentage of partial failures	Percentage of total failures	Total percentage
274–325	71.5	21.4	7.1	100
326–425	40.6	18.8	40.6	100
426–475	11.6	15.2	73.2	100
476 and over	4.7	12.5	82.8	100
Total	20.9	15.8	63.3	100

Coefficient of contingency .44

The lowest failure score obtainable on the basis of our figures, adding the factor of the men's behavior in the reformatory, is 274; the highest is 499. It will be seen that a man coming up before the parole board for consideration, whose record on the seven factors involved gives him a score of between 274 and 325, has better than seven out of ten chances of being a success in post-parole conduct; he has a two-in-ten chance of being at least only a partial failure, and but half a chance in ten of turning out to be a total failure. On the other hand, a prisoner whose record on the six highest pre-reformatory factors and one highest reformatory factor gives him a failure score totaling 476 or over has only half a chance in ten of being a success in post-parole conduct, only one chance in ten of being a partial failure, and eight chances in ten of becoming a complete failure.

The next prognostic instrument might be utilized by parole boards in determining whether to continue parole supervision for men already on parole. Of course, under the existing system, a parolee's period of supervised liberty automatically ends when the maximum limit of his so-called "indeterminate" sentence is reached. In the peno-correctional practice of the future, however, a completely indeterminate sentence will perhaps be found to be necessary for certain types of cases, and in that event such a prognostic device as the one submitted in the following table would be useful.

TABLE V.—PROBABLE POST-PAROLE CRIMINALITY RATES BASED ON TOTAL FAILURE SCORES ON SIX HIGHEST PRE-REFORMATORY FACTORS, HIGHEST REFORMATORY FACTOR, AND HIGHEST PAROLE FACTOR

	Probable status as to post-parole criminality			
Total-failure score	Percentage of successes	Percentage of partial failures	Percentage of total failures	Total percentage
304–350	77.7	22.3	0	100
351–400	57.2	21.4	21.4	100
401–450	45.7	22.8	31.5	100
451–500	18.7	18.7	62.6	100
501–550	9.6	14.5	75.9	100
551 and over	0	8.1	91.9	100
Total	21.2	16.5	62.3	100

Coefficient of contingency .48

The lowest failure rate obtainable, when one adds to the foregoing seven factors that of the behavior of the men while on parole, is 304; the highest is 576. It will be seen that a man already on parole whose case comes up for determination whether the parole board shall discharge him or continue his parole has seven and a half chances in ten of being a success in post-parole conduct, if his record on the eight factors involved gives him a score of between 304 and 350. Such a man has two chances in ten of being at least a partial, rather than a total failure, and the chances of his turning out to be a total failure are probably nil. On the other hand, a man up for consideration of the parole board, for the purpose mentioned, whose total-failure score on the eight factors involved is 551 or over, has no chance of turning out to be a success if parole supervision is removed; he has but one chance in ten of being a post-parole partial failure, and nine out of ten chances of being a complete failure. The value of this prognostic device in determining which ex-prisoners require continued supervision thus becomes apparent.

The next prognostic table (Table VI) could be utilized by judges for recidivists—that is, men who, having already passed through the reformatory and parole systems, are again convicted of crime. For this purpose the six pre-reformatory factors, the highest reformatory factor, the highest parole factor, and the five highest post-parole factors were utilized.

The lowest failure rate obtainable, on the basis of our figures, when one adds to the foregoing eight factors the five highest post-parole factors (making a total of thirteen items on which this table is founded) is 378; the highest is 935. It

will be seen that a man who has already passed through the reformatory and parole systems and has been finally released from parole supervision, but who again commits a crime, has nine and a half chances in ten of turning out to be a post-parole success if again subjected to the reformatory and parole treatment, provided his total-failure score is between 378 and 575. On the other hand, a recidivist up before the judge for sentence on a new offense, whose failure score totals as high as 876 or over, has no chance of turning out to be a post-parole success if again subjected to the reformatory and parole régime. If his prior total-failure record is between 776 and 875, he has two chances in ten of becoming a partial failure,

TABLE VI.—PROBABLE POST-PAROLE CRIMINALITY RATES BASED ON TOTAL FAILURE SCORES ON SIX HIGHEST PRE-REFORMATORY FACTORS, HIGHEST REFORMATORY FACTOR, HIGHEST PAROLE FACTOR, AND FIVE HIGHEST POST-PAROLE FACTORS

	Status as to post-parole criminality			
Total-failure score	Percentage of successes	Percentage of partial failures	Percentage of total failures	Total percentage
378–575	95.2	4.8	0	100
576–675	60.6	28.6	10.8	100
676–775	10.5	47.4	42.1	100
776–875	0	22.7	77.3	100
876 and over	0	5.1	94.9	100
Total	29.4	19.4	51.2	100

Coefficient of contingency .68

and nearly eight in ten chances of turning out to be a total failure. If his former total-failure record is 876 or over, there is but half a chance in ten of his being even a partial failure (rather than a total failure), if he be again submitted to the reformatory and parole routine; while the chances of his again turning out to be a total failure are as high as nine and a half out of ten.

It will be noticed that in all the prognostic tables presented there is a high coefficient of contingency. The last table has the extremely high coefficient of .68. These coefficients indicate the considerable relationship between the failure-score rates obtained by the men on the positive factors and their actual status as regards post-parole criminality.

USE OF PROGNOSTIC TABLES IN INDIVIDUAL CASES

To show more clearly how the prognostic instruments would actually be used by judges and parole officials, we present a

number of illustrative cases showing the failure rates obtained by them on the various factors involved. These are new cases—not among these upon which the statistical tables were based.

TABLE VII. RECORD CHART OF 7 POST-PAROLE CASES

Factors	*Post-parole record of criminality*						
	Successes			Partial failures		Total failures	
	1	2	3	4	5	6	7
Pre-reformatory:							
Industrial habits	43	43	43	59	43	59	68
Seriousness of crime	21	21	67	67	21	67	67
Prior arrest or non-arrest	69	32	69	69	32	69	69
Prior penal experience	47	47	74	47	47	74	47
Economic responsibility	41	41	41	64	41	64	64
Mental condition	60	60	75	75	87	87	60
Total I	281	244	369	381	271	420	375
Reformatory:							
Conduct in reformatory	30	30	30	70	30	70	70
Total II	311	274	399	451	301	490	445
Parole:							
Conduct on parole	*	30	77	77	30	77	30
Total III		304	476	528	331	567	475
Post-parole:							
Industrial habits				66	66	92	92
Attitude toward family				10	50	85	85
Economic responsibility				53	53	85	53
Type of home				44	44	86	44
Use of leisure				81	81	81	81
Total IV				782	625	996	830

* No parole; served maximum sentence

Table VII gives the scores actually obtained on each of the factors involved by seven offenders taken at random. The first three cases are those of men who turned out to be successes so far as their non-criminality during the five-year post-parole period is concerned. Cases 4 and 5 were partial failures, Cases 6 and 7 complete failures. It will be seen that as to Cases 1, 2, and 3, no post-parole factors are given. The reason is that since they were successes and presumably would

again not come up before judges for new offenses, it was not necessary to indicate what their scores as to the post-parole factors were. Only if they again offend and are again about to be sentenced, will their scores as to the factors involved in the post-parole period that followed their *prior* offense become relevant. As to Cases 4, 5, 6, and 7, on the other hand, it is of course evident, by the fact of their having committed new offenses during the post-parole period, that they are failures so far as obeying the law is concerned. But from this fact it can by no means be concluded that they were also necessarily failures in their family relationships, to cite but one of the five post-parole factors. Criminals, like other men, differ as to their behavior with reference to matters embraced in the five post-parole factors. Their record in those respects is perhaps just as important from the point of view of predicting what their future conduct will be as is the fact of their having again lapsed into criminality.

Assume, now, that Cases 2 and 3 are before a judge for sentence, as indeed they were some six or eight years ago. The judge will see that Case 2, whose failure score is only 244 (Table VII, Total I), has seven and a half out of ten chances of being a success so far as post-parole conduct is concerned, if put through the reformatory and parole régimes (Table III). Now if the judge could have before him, in addition to the prognostic instrument based on the reformatory and parole régimes, a prediction table based on *probation,* and if that table indicated that a prisoner with the total-failure score of Case 2 has, say, *nine* out of ten chances of succeeding if placed on probation, then, other things being equal, the court would place him on probation instead of sentencing him to the reformatory. If, in addition to the prognostic tables covering the reformatory and parole régimes and probation, our judge also had scientifically constructed tables on *other* forms of treatment, such as the more rigid régime of the prison, or treatment in special institutions for psychopathic, defective, or other classes, the probability of the court's doing its work intelligently would be greatly multiplied.

Turning now to Case 3, the judge, on consulting the failure-score chart, would find that that prisoner has the score of 369. Looking next at his prognostic table (Table III), he

would see that the chances are only two and a half out of ten of Case 3 being a success if submitted to the reformatory and parole régimes. If, again, our judge has a failure-rate table for probation or some other form of treatment, and the chances of succeeding are found to be better for a person of the type of Case 3 under such treatment than under the reformatory régime, then probation or other treatment would be given precedence over sentence to the reformatory.

Let us next look at Case 1 from the point of view of the work of the parole board. When the prisoners were being considered by the parole board for release under supervision, Case 1, whose failure score of 311 was one of the lowest of the seven (Total II), was denied parole. He was compelled to serve his entire sentence behind prison bars, while Cases 4, 6, and 7, with their relatively high failure scores, were permitted to spend most of their sentence in freedom on parole. Since Case 1 had such a low failure score on the six pre-reformatory factors and the one reformatory factor involved in the parole board's prognostic chart, the chances were seven out of ten (Table IV) that he would be the success he actually tuned out to be, two in ten that he would at least be only a partial failure, and less than one out of ten that he would be a complete failure, if released on parole. With this assurance, the parole board might reasonably have allowed this offender to spend most of his sentence in supervised liberty instead of behind bars, thus returning him much earlier to a normal life in the community than was actually the case.

Case 3, who, in the long run (Total III), had the highest failure score (476) of the three men who were post-parole successes, was a psychopath and a moron, a fact that illustrates the value of psychiatric aid to the court. Knowledge of the mental condition of Case 3 would have materially aided the judge in deciding as to which type of correctional treatment was best suited to the prisoner. Case 3 had only two chances in ten, when he completed his parole, of being the success that he actually turned out to be. In truth, the good result in his case is not to be attributed so much to either the reformatory or the parole system as it is to the fact that almost to the end of his post-parole period Case 3 was in the protected, supervised environment of the army. There but little initiative

was required of him; his food, clothing, and lodging were furnished, and but a minimum of competitive effort on his part was sufficient.[1]

Case 3 illustrates the important point that prognostic devices such as those herein presented are not to be utilized blindly. It is not proposed thereby to convert judges completely into the rubber stamps they are sometimes partially compelled to be by detailed, legislative prescription of penalties to be imposed for various offenses. If a physician, utilizing a prognostic instrument for various combinations of symptoms as an aid to treatment, were to follow such a table blindly, he would soon find himself in trouble. Such a device could only furnish support to his experience and reason; it would not be a substitute therefor. Similarly, a prognostic instrument of the kind herein devised would only aid the judge in performing his sentencing task much more intelligently than he does it to-day. It would not supersede the judge.

But even if busy courts were, because of the pressure of business, to found their disposition of cases entirely upon failure-rate tables, making no exceptions to suit individual peculiarities, the chances are all in favor of the conclusion that, in the long run, they would thereby do a much more constructive work, from the points of view both of society and of the offender, than they are doing to-day.

By way of further exposition of the proposed method, we may now consider several other cases whose failure scores are indicated in Table VII. When Case 5 (a partial post-parole failure) and Case 6 (a total post-parole failure) were up before the judge *the first time,* he could have seen that the former's total failure score is 271, the latter's 420 (Table VII, Total I). Consulting the prognostic chart (Table III), he would have learned that Case 5 had seven and a half out of ten chances of being a success if put through the reformatory and parole régimes, two in ten chances of being a partial failure, and only half a chance in ten of turning out to be a

[1] We have found that certain men do better under supervision, be it military or parole, than without it; others do equally well under supervision as without it. There were 158 men who had army or navy careers (of which the nature of the discharge was known), which terminated before the expiration of the post-parole period.

total post-parole failure. Case 6, on the other hand, had only half a chance in ten of being a success, only a one-and-a-half-to-ten chance of being a partial failure, and an eight-to-ten chance of being a total failure. The judge could thus have ascertained the futility of subjecting a man like Case 6 to the reformatory and parole régime and could have foretold that Case 6 would be the failure he actually turned out to be. On the other hand, the court might have tried Case 5 on probation, if the chances of that prisoner succeeding on probation had been found to be more favorable than his chances of success under the reformatory and parole régimes.

So, too, if the parole board had consulted the prognostic chart (Table IV) when Case 6 was being considered for parole, it would have seen that the chances of that prisoner being an ultimate success if released on parole were less than one-half out of ten, since his score was 490 (Table VII, Total II). It would also have seen that the chances of Case 5, with his score of 301, were seven out of ten that he would be a post-parole success, two out of ten that he would be a partial failure, and less than one in ten that he would totally fail.

Assume, now, that Case 5 and Case 6 have again been convicted after passing through the reformatory and parole systems, and are now up before a judge for sentence. The judge will see (Table VI) that Case 5, whose failure score covering pre-reformatory, reformatory, parole, and *post-parole* factors pertaining to his previous criminality is 625 (Table VII, Total IV), has six chances out of ten of being a success if again put through the routine of reformatory and parole, a three-in-ten chance of again being a partial failure, and a one-in-ten chance of this time turning out to be a complete failure. If prognostic tables pertaining to other forms of treatment would show a higher possibility of success, such treatment, rather than another trial in the reformatory and on parole, would be "indicated", as the physicians say.

Case 6, a complete failure, has the extremely high failure score of 996 (Table VII, Total IV). Table VI shows that the chances of Case 6 turning out a success, if again subjected to the reformatory and parole régimes are nil; the chance of his being a partial failure is one-half out of ten; while there is a nine-and-a-half chance in ten of his continuing to be a

complete failure. If, again, a failure-rate table as to some other form of treatment should indicate that for a prisoner of the type of Case 6 there is a fairly good probability of success, then such other treatment might be tried. If the chances of Case 6 being a total failure under other existing forms of treatment are as high as under reformatory and parole treatment, then society must provide for wholly indeterminate, probably lifelong, incarceration for men of the type of Case 6; at least it must do so until such time as it has, by experiment, greatly improved and supplemented existing peno-correctional methods.

Examination of the history of Case 6 shows that he has long been a chronic alcoholic. In his case, therefore, indeterminate incarceration in an industrial camp or farm, with facilities for the medical and psychiatric treatment of alcoholics and an opportunity to earn at least part of a living for his family, is perhaps the most promising treatment.

Case 4 was diagnosed by the reformatory psychiatrist as a psychopath. Difficulties of social adjustment are frequently the characteristics of this type of distorted personality. When Case 4 is up before a judge for a new offense, it will be seen that the failure score of this convict is 782. Turning to the prognostic device (Table VI), the judge will learn that there is no chance of Case 4 turning out a success if again subjected to the old régime, and two out of ten chances of his being a partial failure; while the chances of his total failure are somewhat greater than seven and a half in ten. Now if there is available a specialized institution for psychopathic personalities, where good psychiatric facilities and industrial and educational opportunities are afforded, the judge, who perhaps the first time wanted to try Case 4 under the ordinary reformatory and parole régimes before committing him for a wholly indeterminate period to the specialized institution for psychopaths, may now decide to send him to such institution; unless, of course, the prognostic tables as to other forms of treatment indicate that those should first be tried.

One might similarly analyze all the cases studied. Sufficient explanation has, however, been made to indicate exactly the rôle that might be played in the scientific administration of justice by some such prognostic instruments as herein proposed.

In the foregoing illustrative cases, the pre-reformatory factor of mental condition has been shown to be of great importance in determining what type of *treatment* to apply to a particular case. Is it also absolutely indispensable as an element of the *prognostic* instruments? It must be remembered in this connection that the vast majority of criminal courts in the United States are not yet awake to the possibilities of psychiatry and psychology in the effective and humane administration of criminal justice. Many of these courts do, however, have some form of opportunity for social investigation of some of the cases that come before them for sentence.[1] This service is most frequently furnished by probation officers, who are supposed to make investigations of the social conditions surrounding the accused, submitting their reports to aid the court in the proper disposition of cases.

Now we have found that, at least so far as our cases are concerned, the efficiency of the prognostic devices herein described is hardly impaired [2] if one omits, from among the factors to be considered by the court, that of the mental condition of the accused. A possible explanation of this is that much of the individual's mental constitution is reflected and expressed in his conduct. Hence, it would seem that so far as *prognosis* is concerned, courts without the services of psychiatrists can get along fairly well, provided they have careful social investigation of cases. When, however, there is judicial recognition of mental disorder or personality distortion as one of the important causes involved in the continuation of antisocial conduct in certain cases, and when an intelligent disposition of those cases in the light of such findings is attempted, the services of a good psychiatrist will become indispensable to any modern judicial system.

[1] See *Psychiatric Service in Penal and Reformatory Institutions and Criminal Courts in the United States*, by Winfred Overholser, M.D. MENTAL HYGIENE, Vol. 12, pp. 801–38, October, 1928.

[2] The coefficient expressing the relationship between the pre-reformatory factors (*omitting* mental condition) and post-parole criminality is .40; that between the pre-reformatory factors plus the reformatory factor and post-parole criminality is .39; that between pre-reformatory plus reformatory and parole conduct factors, and post-parole criminality is .45; and that between all these plus the five post-parole factors, and post-parole criminality is .69. It will be seen that these coefficients are essentially similar to those in the prognostic tables III to VI.

WEAKNESS OF EXISTING PRACTICE

In the foregoing pages we have presented instruments for rendering the work of courts and parole systems much more scientific than it is to-day. Some reminder of the present *modus operandi* might appropriately be given here by way of contrast. The relationship between the total-failure score on the factors embraced in the preceding prognostic instruments and post-parole criminal conduct was found, as we have seen, to be very high. The coefficients expressing that fact ranged from .44 to .68. In the research upon which this article is based, it was, however, established that the coefficient expressing the relation between type of offense committed—that is, whether it was burglary, larceny, robbery, or a sexually motivated crime—and post-parole criminal conduct status is but .11. This coefficient is so low as to indicate only a negligible relationship between nature of offense and post-parole conduct. Again, the coefficient of contingency between the seriousness of offense for which the men were sentenced to the reformatory and their post-parole criminal record was but .05 [1]—that is, practically nil. *But the modern disposition of cases is fundamentally based on these factors!* [2] In other words, legislative prescription of penalties and judicial sentencing are founded upon considerations almost wholly irrelevant to whether or not a criminal will thereunder ultimately be a success, a partial failure, or a total failure. Can any proof of the unscientific nature of the contemporary treatment of this problem be stronger? After all, is not one important object of punishment, even in the eyes of the most conservative, to prevent the offender from continuing in criminality? The absurdity of the existing practice is brought out by statutory provisions of which the following is typical:

> "Whoever steals, or with intent to defraud, obtains by a false pretence, or whoever unlawfully and, with intent to steal or embezzle, converts or secretes, with intent to convert, the money or personal chattel of another, whether such money or personal chattel is or is not in his possession at the time of such conversion or secreting, shall be guilty of

[1] Table I, page 686.

[2] The indeterminate sentence and probation of course allow the judge some scope for individualization. But essentially the limits of his discretion in this important work of sentencing offenders against the law are marked out by considerations of the kind mentioned.

larceny, and shall, if the *value* of the property stolen *exceeds* $100, be punished by *imprisonment* in the state prison for *not more than five years* or by a fine of not more than $600 and imprisonment in jail for not more than two years; or, if the *value* of the property stolen *does not exceed* $100, shall be punished by imprisonment in jail for *not more than one year* or by a fine of not more than $300; or, if the property was stolen from the conveyance of a common carrier or of a person carrying on an express business, shall be punished for the first offense by imprisonment for not less than six months nor more than 2½ years, or by a fine of not less than $50 or more than $600, or both, and for a subsequent offense by imprisonment for not less than eighteen months nor more than two and one-half years, or by a fine of not less than $150 nor more than $600, or both."[1]

The nature of the peno-correctional treatment to be imposed is thus made to hinge upon the value of the property that happens to have been stolen and the person or place from which it was taken, rather than upon the make-up of the offender and the probabilities of his responding to one or another form of treatment.

SUMMARY

In the foregoing pages we have presented a series of prognostic tables and illustrative cases, indicating that it is possible to introduce scientific method into the work of criminal courts and parole boards. Under the existing system, judges either are compelled to follow blindly the dictates of a legislature which has set down in advance the precise punishments to be imposed for each offense, or are governed by considerations almost entirely irrelevant to the factors that are most strongly associated with the future conduct of criminals. This practice has been demonstrated to be unscientific. On the other hand, it should be obvious, from the illustrations given, that judicial or administrative guesswork or predilection, irrelevant argument of counsel paid to "get my client off" or at least to reduce the punishment, or other extraneous considerations would, by means of the intelligent use of some such device as that herein described, be replaced by a truly intelligent approach to the problem. The instrument presented in the foregoing pages is by no means a perfect one. Much more research and refinement of method is needed. But it constitutes a step toward a scientific management of the problem of crime by the courts and administrative agencies.

[1] Mass. Gen. Laws (1921), c. 266, § 30 (italics ours).

THE RELATIONSHIP OF THE PSYCHIATRIC CLINIC TO THE JUVENILE COURT *

J. S. PLANT, M.D.
Director, Essex County Juvenile Clinic, Newark, New Jersey

DEEPER than our definite subject matter lie the unanswered questions as to what a "psychiatric clinic" is and just what it does. Indeed, what does the psychiatrist of to-day hold to be his peculiar field? Without going far astray, one may find eager support for two diametrically opposed views. On the one hand, the psychiatrist, with probes of magic intuition, is expected to discover incipient insanity; his clinic is a sort of preventorium. Courts, equipped with psychiatric service, proudly proclaim possession of the means for weeding out the intellectually or emotionally handicapped or unfit. Social agencies interest themselves in the percentage of frank "mental hazards" amongst their chronic cases, and for this sort of study call in a psychiatrist. On the other hand, just as widespread is the view that (having, mayhap, gained his knowledge from the emphasized examples of frank mental disease) the psychiatrist best understands the basic laws of *all* mental reactions. Here the psychiatrist ceases to interest himself particularly in mental difficulties, boldly informing the world that it may look only to him for the explanation of the psychic motivation of all life. Interestingly enough, he quite disdains intellectual defect and the hint of insanity; these are the hopeless cases with which the psychiatric clinic cannot be burdened.

Somewhere between these extremes must we find ourselves in this paper. When two intelligent groups are certain, respectively, of two opposing points of view, neither is correct. We state the hypothesis that has represented the basis of our

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work for the last five years.[1] It is practicable, for it has worked. Its theoretical expediency, or even validity, remains open to question.

We present a theory. An historical approach involving recent developments will give it better perspective.

What brought the psychiatrist into court work? First appears the sheer genius of the pioneer—Dr. William Healy—who, entering the work of the Chicago juvenile court, early demonstrated there a wealth of psychological and sociological material. Interestingly enough, he brought the method of the physician to these problems just at a time when there was a growing (but still vague) feeling that the whole problem of maladjustment was an unusually expensive and misunderstood one. Thus the appeal for aid from the psychiatrist (beyond a startled realization of Healy's discoveries) is largely due to the failure of the forces already at hand to cope with the problem.

What, then, is this physician's point of view in problems of maladjustment? He is much less interested in what the fact is than in *why* it exists—the fact has value chiefly as a symptom. Called to a fevered patient, the physician does not assemble an adequately unintelligent jury to determine that the patient really has the fever, as alleged. His interest in the fever itself often ceases with the merest gesture to assure himself of its presence. His real interest is in *why* the patient has a fever. The lawyer scales the criminal on the basis of the enormity of the crime—the *bulk* of the antisocial act. The psychiatrist (this seems axiomatic) is in no sense interested in this question, often feeling that the criminal who commits some trivial offense is much sicker than he who has committed a great offense. Thus in the infections every physician is aware, for instance, of the mild and insinuating symptoms of tuberculosis. The implied analogy in the field of conduct disorders is interesting and arresting. To the physician a high, raging

1 Any discussion of the five years' work of the Essex County Juvenile Clinic would indeed be empty without the name of the Honorable Daniel J. Brennan, for that period judge of the Juvenile Court of Essex County. My deep personal debt for friendship and counsel is here warmly acknowledged; and for whatever of real worth lies in the theory presented in this paper, a large share of credit is due to the keen criticism that he so freely gave—and sought.

fever may be a bad or a good sign, depending upon what it is a symptom of.

Is this interest in causes, in basic factors *back of* the delinquency, a real forward step? Before giving an affirmative answer, note this—that where the physician has really entered the social field (where his field of responsibility has gone from the individual to the social situation) he has shifted his primary interest to the question of the existence of the fact itself. In an epidemic, the public-health officer watches the *number of cases*, wants very much to know whether you have a fever or not, and is little interested in anything beyond the fact of the presence of the fever and its danger to others. That is, the lawyer is interested in the fact as a fact (Did it happen?); the physician is interested in the fact as a symptom (Why did it happen?). When, however, the physician becomes interested in medicine as a *social* problem, he, too, becomes interested in the fact as a fact. That is, the juvenile-court judge is interested in the fact as a fact; the psychiatric clinic is interested in the fact as a symptom. But if the psychiatrist had to accept the *social* responsibility that, of necessity, is the court's, would he not, too, become interested in the fact as a fact? [1]

With the definite theory of conduct as a symptom, the psychiatrist early turned to the question, What is it a symptom of? What, he asked, is wrong with the child? Never before has human ingenuity and verbosity been more garishly displayed. Physical and intellectual handicap, psychopathy, inferiority, emotional immaturity (to mention a few)—each in turn has been brought forward as a dazzling new way of explaining what is wrong with the child. The delinquency is not wrong in itself; it is only a symptom of something that is wrong with the child. With this point in view, let us consider certain cases; they are typical of a large fraction of our work.

Johnny,[2] a lovable, normal, bright-eyed, tow-headed young-

[1] For literary purposes we assume here a clarity of differentiation that in no sense exists. In reality the fields of interest largely overlap, and the differences lie principally in the points of primary emphasis.

[2] It is with regret that we bow again to literary expediency, which forces brevity of description and the use of cases in which the issues are clear cut. We feel, however, that we have not done violence to the issues involved, though, patently, they play their part in everyday life merely as lights and shades.

ster of nine, was a repeated runaway from an extremely nice home. Friendly help, coaxing, bribes, probation, punishment had been of no avail. Mr. and Mrs. R., kindly, generous souls of some fifty summers, had decided to adopt a child, having had none of their own. The orphanage had prevailed upon them to take Johnny (then almost nine) as it was "so difficult to place children who were really grown". Thus it was "out of the goodness of their hearts" that they took Johnny. But Mrs. R. is a normal, average woman—which means that she really wanted a baby, some one to cuddle, to need her. And Johnny is a normal, average nine-year-old boy—which means that he really wanted to be independent. Isn't it interesting that Johnny ran away from the loving, protecting home because he was "normal"? Johnny finally spent two years in a state industrial school because a normal child, in contact with the needs of a normal pair of parents, worked out the situation as he saw best. Nor does there exist a family worth its salt in which the parents do not seek to guide while the child seeks not to be guided.

Mary has superior intellectual ability and has done well up to this last year of high school. Now she dreams and dawdles all day, seeming not to want to graduate. She wants to be a designer and has the ability to be one. But her family has long since planned that she be a singer; thus her imminent failure, that the decision may be put off for a year. Why this conflict? Mary's mother had wanted to be a singer. There was no money, and she became a stenographer. She used to say (as she tells it): "Yes, I am a stenographer, I am a stenographer; but when I grow up, I will marry and I will have a daughter and she will be a—singer." Now Mary is a social problem, an idler, a potentially serious maladjustment, because she is normal enough to want to live her own life and because her mother is normal enough to want to mend the broken promise of her own life in the life of her child. Nor is there a parent worth his salt who in earlier days, as an answer to whatever of disappointment, of disillusionment, of failure, life offered, has not cried: "My *child* shall live it differently!" Nor is there anything abnormal, or queer, or immature, or unexpected in the repetition of a maturer time: "My child *shall* live it differently." It is precisely because Mary and precisely because her mother are normal or average or ex-

pected that the difficulty with the social institution arose; and, just as with Johnny, we are dealing with a problem as common and as usual as any that we have in clinic practice.

Strife—in the adjustments of normal families. Is it not interesting that the judge rather of necessity saw primarily the preservation of the social institutions of the family and the law, and that the psychiatrist just as naturally saw primarily the fulfillment of the needs of the individuals?[1] We reëmphasize—these situations did not arise because of anything wrong with the delinquents; in fact, it was because they presented the most common cravings of the race in fullest flower that the trouble arose. In the struggle of the individual child against the conservatism, the dominance, the determining love of its family, the court must ever tend tacitly to align itself with the social institution, and the psychiatrist with the individual.

Another boy—daring, tried in many institutions, theatrical, punished, glorying in it all. Charlie has knocked at the door of every serious crime. When we saw him—long launched on his career—he, with sullen defiance, looked forward to another sentence. And all this because as a youngster he was "only a runt". A runt, eh? He'd "show 'em"! This indomitable drive to victory over the difficulties of life leads its various ways, and who is wise enough to predict its path? Charlie strove on—to the electric chair—because "he'd show the world", nor has any conqueror of the apparently insuperable rejoiced in admirers' plaudits more than did Charlie over the acclaim of neighborhood gangs that "that boy—*that runt*—wouldn't stop at anything".

Harold was another terror—only eleven, but the feared bully of a large community. No mother of younger children but knew and feared Harold. An orphan, he had been in a "home". We still remember the flash of his eyes as he told us that the children would "never know—*never*"—of this earlier experience. Cheated by fate—his every defense of self-respect thrown wide open through his parents' desertion, he boldly made his way as he saw best, conquering the com-

[1] Obviously the juvenile-court judge is not nearly so blind to the needs of the individual—nor the psychiatrist to the demands of social order—as here depicted. It is again rather a matter of the points of paramount emphasis.

munity that could so easily have crushed him, subduing those who really were his masters. Harold wanted only (as does every other normal person) a "place in the sun". He now represents one of those miracles that a new teacher, a new room, and a bit of praising friendship can produce.

In Charlie and Harold we see the struggle of the individual to meet satisfactorily the demands of the community. Nor is there a normal individual who, after adjusting to the family, has not this second adjustment to make. Both of these boys were "normal". Is it not precisely because they were "normal" that the trouble arose in such intensity? Again two whose "rights" are to be studied, understood, championed—the individual and society. Again is it not the psychiatrist who sees the individual and his needs and the court that "champions" society?[1]

One more adjustment all children must make—that of getting the daily bread, of earning a living. Beatrice is a "typical" child of southern Europe—keen, alert, intelligent, with a rich, full-blown emotional life. We saw her at nineteen—an unmarried mother. Through with school, she had sought her satisfactions in factory work. Her wages were fair and her work typical of much of our factory work—so automatic in character that were she to move her hands one whit out of a prescribed path, she would lose a finger or so. Beatrice might talk a bit with the others if the conversation was not too engrossing. Her sexual experiences seem but the natural heightened emotional compensations for the long periods of enforced and rigid repression.

Our tremendous economic organization has necessitated this rigid stratification of its units so that they must seek their emotional outlets outside their work, and with sufficient intensity to "make up" for the day of phantasy. Society hails the new economic era, and society interests itself in the illegitimacy. How these are tied together in the individual—that is

1 Unfortunately in the four cases just cited our effort to depict the essentially normal nature of human strife and clashing interests has given the impression that had the psychiatrist's (the individualist's) contribution only been known in time, the difficulties would not have arisen. We believe this view to be false—a distortion in the picture arising from the false perspective given by a brief recital of only those aspects of the cases that have to do with the point immediately involved.

the purview of the psychiatrist. The court takes cognizance of the social facts and makes its disposition on that basis.[1]

Here, then, are five children, all more or less serious social problems, all of them expressing the conflict—as old as the ages—between the needs of the individual and the needs of society (expressed in the family, the community, and the industrial organization). We will not take the time here to enlarge upon the perfectly obvious fact that these children are problems largely because they are equipped to express in rich fullness the demands of every ordinary individual. We have found the court interested in the fact, and the psychiatrist in the individual who manufactured it. Then, turning to the matter of "fixing the blame", we again found the duality, with antagonistic drives between the individual and society. Again the psychiatrist understands and emphasizes the individual's needs, whereas the individual comes to court only when these needs strongly clash with the needs of organized society, whether they be the needs of the family, of the community, or of industry.

With so much of analysis as to the method of approach and the type of difficulty that this bares, we approach the matter of therapy—the question, "What are we doing to do about it?" Again, mayhap, we will meet this antithesis between the needs of the individual and those of society.

Often the psychiatrist sits with the whining, complaining, bothersome boy who talks and talks his troubles, who can indefinitely regale the world with the story of repression, misunderstanding, tyranny. Our persistent commentary is, "Why doesn't he *do* something about it? Why doesn't he really protest? He is in an impossible situation, but preferably to losing his three meals a day and a roof, he accepts the situation!" But suppose the child does do something about it, does show the full-blown flower of a real individual? Then he becomes a delinquent! A truant! A runaway! Isn't it interesting that the psychiatrist—individualist that he is—so often sees in this delinquency the best proof that he is dealing with a child of real promise?

Four years ago we saw a persistent and chronic young thief

[1] Here again I would emphasis vigorously the point made in the note on page 712.

of thirteen, plotting ever greater and more bizarre escapades; his one interest was that of committing "perfect crimes".[1] At seven Charles had been discovered by his mother making some childish examination of his sex organs. The direst consequences were pictured by the frightened parent—and the matter dropped. Then, at eleven, when the real sex urge appeared, and Charles felt that it represented only a terrible sin, he turned to reading as a means of escape; with the recurring urge, more and more exciting books; then, to still it, the developing of his own plots; with more insistent recurrence, the commission of simple and then of more serious delinquencies (usually burying or discarding the stolen goods)—always to still the urge toward masturbation. A restless, tense youngster—Charles yet was triumphantly happy that he was "clean". Healy has so thoroughly covered this field of the rôle of conflict in misconduct that we bring up this case only as an example (oft-repeated in our clinical experience) of the fact that the psychiatrist often fears punishment or its threat as something that but diverts the force of some fundamental drive, which thereupon finds its outlets in an insatiable urge to delinquency. Thus, punishment, the one most available, most usable tool of the courts and society, often becomes to the psychiatrist the surest method of producing crime and maladjustment.

Why, then, does the court so depend on punishment and threat? Is it (as psychiatrists so often claim) merely another instance of the lawyers' blindness to the glory of the new dawn? Is it only the psychiatrist who is permitted to kiss those first-appearing, rosy-hued finger tips of Eos? Punishment is not used by the courts because it is an old-fashioned way to treat the individual, but because it is, in the eyes of society, a thoroughly modern and up-to-date method of deterring others from crime.[2] Again this *social* motive! We psy-

1 For those interested in the contagious aspect of delinquencies, we may say that this entire case, with quite a bit of its therapy, antedated the Loeb-Leopold difficulty in Chicago.

2 In this matter of punishment perhaps more than anywhere else there appears the antithesis we are depicting. We often recommend to the court that the child be "punished", recognizing this as a useful form of therapy in certain situations. We never, however, consider punishment from the point of view of deterring others, leaving this social consideration to the court. The tools of the two agencies are the same, but used with different purposes.

chiatrists inveigh against the use of punishment; it is easy to do this as long as the final responsibility in the matter is not in our hands.

Again we have this conflict between the individual and the social demands—between the point of view of the psychiatrist and that of the juvenile court—and it is the thesis of our belief and hope that this conflict will grow in size and sharpness as the two perfect their knowledge and power in this field.

Turning now to some deeper implications, shall we again find the antithesis? Our most prevalent, time-consuming, and insistent of occupations is the happy pastime of determining "whose fault it is". The accompaniment of every juvenile encounter is: "*He* started it. It wasn't *my* fault." To what flimsy webs would all family disputes shrink could we eliminate the moot question of "Whose fault was it?" We accept an event as a national disaster only when at least one commission has been appointed to "fix the blame". The psychiatrist affects a decidedly contrasting attitude—one of not trying to "excuse" the child, but rather of trying to "understand why" he did a certain thing. Many of us ban the use of such words as "admit" and "deny" in our clinic records as part of an effort to get away from this most paralyzing of all human activities. Society's attitude—the individualist's attitude! "Fixing the blame" does not rest upon an old-fashioned or outworn philosophical notion; look into your own social relationships if you think otherwise! Go to hear the most prevalent cry of the streets teeming with children if you think so!

Well enough, with luxuriant verbiage, to say that the whole world is infantile, immature, suffering from this complex or that, from which we leaders—we, like some modern Moses—will lead them all to maturity! Society in the past in all its dealings, society now in all its dealings, interests itself in this question, and society *will* interest itself in this, our Lilliputian darts to the contrary notwithstanding. This seems to us necessary from the point of view of the solidarity of the social organization. How else is society to feel that it is weeding out its enemies?

There is a wave now of criticism of such "metaphysical antiques" as the notion of "responsibility" and of the "knowledge of the difference between right and wrong". We

are told that the courts must come to realize how ancient are their ways. I will not take your time for a philosophical discussion in which I am not at all an able protagonist, but I have quite convinced myself that, bothersome as are these questions, they are not in the least old-fashioned. *Social* institutions (for their own protection) *must* fix the blame and "responsibility", and "right and wrong" are necessary corollaries. Don't misunderstand me. In our individual, small groups we can well dispense with all these notions (besides, we have no *social* responsibility ourselves), but they are necessary social questions. Again the antithesis!

What, then, is the relationship of the psychiatric clinic to the juvenile court? In *drives, needs,* and *outlook*, there is an antithesis, and this antithesis should grow, the more the two agencies develop and perfect themselves. We have little sympathy for a "closer coöperation" between court and clinic. In every act, criminal or not, there are the two factors—the individual who does it and the society or environment that is affected by it. In the relationship of the psychiatrist to the judge, we have the picture of two persons with such divergent interests and training as to represent really opposite points of view, both seeking the same truth or solution for some problem. The essential point of our thesis is that this solution will be arrived at by struggle and the balancing of opposite views (in antagonism) and not by agreement. The psychiatrist *should* make the work of the juvenile-court judge more difficult, and it is our prediction that (in all friendliness) the development of the psychiatric clinic will in future increase the difficulties of the work of the juvenile court. By so much, of course, will the psychiatric clinic increase the efficiency of the court. To the judge now, and for the future, belongs the social responsibility and final disposition of all the data. We have little patience with any notion that this work should be taken out of legal hands even in the juvenile court. Our progress must ever rest upon the solidarity of our social institutions. Tugging and straining at this leash is always individual initiative, growth, and idiosyncrasy. In our total social structure, that is a necessary element. To present its fullest claims before the court, the psychiatric clinic exists. Our recommendations assume for the moment

the paramount interests of the child, as if the whole world were to be built about his needs.[1] It is, and will be, for the juvenile court to take these recommendations for review and replacement in the light of the needs of the solidarity and progress of our social institutions.

[1] Again the physician's individualism and its antagonism to the drives of society! On the battle field succoring the wounded; can nations afford thus to melt the distinction between friend and enemy? In the court giving unequaled service in the constructive assistance of the prisoner; can society afford thus to single out its misfits for opportunities enjoyed by no others? In the home sympathetically fighting for the life of the child with pneumonia; can the family afford thus to forget all the concept of "fault", "blame", "responsibility", in the matter of wearing the rubbers, forgetting the coat, or whatever measures are meant to keep the child from "catching cold"?

THE GIFTED CHILD AND HIS TEACHERS

HERBERT AUSTIN AIKINS, PH.D.
Professor in Western Reserve University, Cleveland

"GEORGE is almost eleven years of age. He has been brought up by a mother who is very refined and who has used every influence for good for the child. George's mental test showed an I.Q. of 155—the highest in two classes. He is well-read and able to give much outside information in geography, history, and so forth. He is what Green (after Jung) would call an introvert—reading many library books. He likes stories of heroes. He takes prominent parts in school dramatics. He is interested in mechanics and in all of the sciences he is able to comprehend.

"However, George is lazy, or seemingly so, never exerting himself at home or school in any way except to please himself. His grades are usually low except in geography and history. His papers are written so poorly that his teachers can scarcely read them. Nothing any one can do or say seems to influence him to do any better. He is in the 5A class in school.

"What can be done for this child? Is he a genius and should he be left alone somewhat, or should he be urged to a greater degree? His mother is more than anxious concerning his welfare."

This is all I know about George. The question was handed to me once by a teacher; and to establish rapport with a new class of thirty public-school teachers, I read it to them and asked: "If George were your problem and you had a free hand, what would you do?"

A few days later, I read the same question to another group, of fifty-one teachers, studying the same subject, in another section of the city.

The answers from these eighty-one teachers surprised me. Written on the spot with no time for thought or consultation, they revealed a spirit, a conception of educational ends, and

a trained technique entirely strange to those who have not kept track of modern educational trends.

In studying the responses to my question, I treated the two groups differently. From the group of thirty, I picked out typical papers which I quoted in full to give undistorted pictures of the individual teachers who wrote them. With the group of fifty-one, I ignored the distinction between individuals and tried to gain a picture of the group as a whole by classifying and counting all the different answers to our problem suggested by its various members. The two methods of dealing with the teachers' answers left the same general impression. And so, for the sake of brevity, I confine myself here to the classified answers from the larger group.

The fifty-one teachers in this second group make between them some sixty-nine suggestions.

Four of the fifty-one teachers, and four only, suggest measures that involve the exercise of direct arbitrary authority. They would lend George none of his beloved books or give him no place, or no prominent place, in dramatics, and so forth, except as a reward for honest work and tidiness.

Twenty suggestions are of some direct personal appeal—four of them to reason, six to some emotion, ten through his heroes.

The four who would appeal to reason would try to make George see that in life we all must do many things that we do not enjoy, or please others rather than ourselves.

The six direct appeals to emotion are these:

"If all other measures fail, I'd be tempted to try shaming him into being less lazy and slovenly."

"I'd praise him for good work along his chosen lines while encouraging him to do things for others, even if he does not like them or take a pride in them."

"Try to make him like me well enough to start doing things for me, personal things at first, and school work later."

"Go on the theory that his so-called laziness may be due to lack of sympathetic understanding on the part of parents and teachers, who have failed to appeal to his better side."

"Make myself interested in what he does and ask to be shown his difficulties."

"Show him a few neat, well-written papers from others and tell him that I have confidence in his ability to do as well."

The ten who would appeal to George through his heroes would arouse his pride by referring to them. Get him to emulate some of them. Emphasize the qualities that he must develop if he is to be like them. Tell him that Lincoln and others worked for what they achieved and were not slackers who just depended on their natural ability. Make him see that many heroes were such because their aim was to serve; that Theseus, Hercules, Roland, Lindbergh were all ambitious. Make a sort of game with George as the hero doing hard sums. Direct his reading to people who have really amounted to something, not fictitious characters, and discuss them and the causes of their success with him, but do *not* tell him he'd do well to emulate them.

Ten of our fifty-one teachers suggest leaving George pretty much alone—one, because he's hopeless ("He has been raised to think only of himself. We can't do much at present. If he is lazy, the chances are he will never change."); two, apparently, because genius finds its own way ("He may be a dreamer and become a writer, inventor, or genius of some sort." "If he is really a genius, he will be successful in the end anyway."); the rest, because there is nothing much the matter with him ("He may not be really lazy and may be getting far more out of his school work than his schoolmates." "George is quite normal. It is natural to do what one likes to do. Writing is mechanical and not especially interesting. That is why he would rather spend his time on reading. I would encourage him to do what he enjoys, because he seems to enjoy the desirable thing." "He can take care of himself. I know a similar case." "He will grow out of it when the right time comes. Papers will be neater, and he will try to come up to the standard expected of him." "Eleven is just the age when he is investigating his world." "Surround him with his books and leave him pretty much alone." "He has had too much attention called to his lack of doing things, and his mother has done too much for him and his 'good'. Don't urge him; grade him as he deserves; let him suffer the consequences of his laziness, even though you may have to manufacture them. But do not rub it in.")

Five suggest getting George out-of-doors or at least into the world of material things and stern necessity: "For the sake of his health draw him away from his books to play and outdoor life." "Encourage outdoor sports." "Give him the materials and let him make things. It will give the satisfaction of achievement." "Mechanical work will help his laziness." "Make him earn money for the things that he wants, and perhaps even for some that he needs."

Twelve would arrange for social appeal through his mates in or out of the classroom: "His selfishness and laziness might be caused by not being socially inclined, so the best thing is to allow him to play and work in groups." "He has probably been kept from mingling with other boys." "Encourage social life and companionship with children whose opinion and competition would spur him on." "Create a social situation in which he would become aware of his shortcomings, or, rather, forget himself in the group activities." "Have him compete"—even get him into an orchestra, with some instrument that he could learn easily (to build up his social confidence). In the classroom, the proposed social drive is combined with the intellectual: "Make him a group leader", and give him plenty of responsibility for undertakings that require brains and leadership and that would go flat if he shirked, or encourage him to help his class, so that he may have an increased sense of responsibility and the satisfaction of helping others.

Eighteen of our teachers would try to fit George's school work to his intelligence, six of them by advancing his grade or putting him in a special class for the gifted; the other twelve by finding enough work for him where he is—research work, difficult problems in dramatics, history, and geography (the things he likes)—to arouse effort, keep him from getting lazy, and give him the joy of accomplishment, though one doubting sister adds, "But of course I would not neglect the things I deemed necessary for his intelligence." Some of the twelve would correlate the other subjects with those that he enjoys. One, for example, would get him to improve his handwriting by encouraging him to write to publishers and others for books, catalogues, or information about the play or project in question. One would let him specialize and not make him

dislike the school by crowding other things on him, but find and train him for a vocation that would suit his special abilities.

In the case of the last twenty-five suggestions quoted (as well as of the preceding ten that advise "leaving him alone"), note how the teacher herself remains in the background. There is nothing arbitrary, nothing hortatory, emotional, or in any way personal in her proposed dealings with the boy. She is not just another woman saying the things he has already heard—to no effect—often enough at home. She is a trained tactician, depending on forces beyond herself, which she may go to infinite trouble to assemble, as it were, entirely by chance.

Note also the spirit of nearly all the answers from our eighty teachers. There is no question of maintaining the prestige of the school or of the teacher herself; no question of exacting blind obedience or submission; no question of writing or arithmetic for its own sake; no big I and little, helpless you. It is a question of skillfully managing to have the boy himself march on to victory, with a spirit of achievement and splendid self-respect, whether he begins with the school arts, with sport and social life, or with material construction.

People of the more prosperous classes are always finding fault with the schools: they are not thorough enough; they teach too many frills; their graduates join an office force and don't know how to spell, or how to think (as if school-teachers could confer brains!), or how to subordinate themselves entirely to the interests of their masters. And doubtless many a pedant will sneer at "research" carried on by little boys and girls. But if frills make for social adjustment, self-respect, and a comfortable sense of belonging and coöperating; and if "research" teaches a youngster to go ahead and get information where he can and not be afraid that a newspaper or a book of reference will bite him, is not the technique of the school as well as its spirit something incomparably better than people even dreamed of forty or fifty years ago, when canings, impositions, and detentions were the order of the day (at least in one place I could name), and when teachers and preachers conspired to produce stereotyped reaction patterns and a broken and contrite spirit? Perhaps even the

elementary schools can contribute to a liberal education in the sense of helping to make a free man really free—liberating him from spiritual bondage, from the fears, fixations, childish taboos, and inhibitions that keep him enslaved and therefore at odds with himself, rebellious, and unreliable.

But it is George, not his teachers, that I was asked about. What if he is a genius?

Well, in the first place, that does not mean that he is destined to be a freak, a rake, or a drunkard. Lombroso's old theory of genius as degeneration has been exploded long ago, and more recent studies have shown that gifted young people are likely to be particularly sane and human. So the teacher need not get ready to throw up her hands and say: "But for the grace of God there goes a future reprobate!"

In the second place, a genius does not spring, like Minerva, fully armed, from the head of Jove. He learns easily, to be sure; but that does not mean that it makes no difference what he learns or that early training does not count. It counts enormously, as Miss Cox has amply shown in her study of the early life of great men, to which we shall presently recur.[1]

The genius, the average man, and the moron are all subject to the same emotional drives and to the same laws of perception and habit formation; and so, in a sense, they are all subject to the same educational influences. The teacher need not be wholly at sea. Yet the quantitative relations are different, a very little instruction, explanation, or repetition achieving for the genius what may require endless reiteration for the moron; so much so that when it comes to much beyond the emotional tone that she sets and the definite information that she can give, the average teacher may be a good deal more of a nuisance than of a help to the gifted child. Hence the wisdom of the suggestions that for the most part George should be left alone. In good books he may meet his equals.

In the third place, the genius is not so far ahead of everybody else that there is never any question as to who should be included in that class. There are always likely to be a number

[1] J. B. Watson has been so much impressed by the effects of training on the infants whom he has studied that he issues a playful guarantee to make anything—from "merchant, chief" to "beggar man, thief"—out of almost anybody, if he can only get hold of him early enough.

of lesser geniuses or near-geniuses not so very far behind the genius *par excellence,* still more near-near-geniuses behind them, and so on, back to the great mass of average people. The result is that the word "genius" like the word "giant" is used so loosely that it is practically useless.

To gain something more precise, Sir Francis Galton substituted for it the words "eminent" and "illustrious," with the understanding that the former term could be applied to about 250 men out of a million (*i.e.,* one in 4,000), and the latter to only one in a million or in many millions, a man so great as to have his death regarded as a matter of national importance and perhaps receive a public funeral.

It takes great gifts to attain such luster, and Galton recognized that it took physical health and interest as well, to say nothing of opportunity (of which Galton thought there was plenty for really outstanding powers) and freedom from unduly hampering fears, fixations, and inhibitions, about which we know more now than was known in Galton's time.

Our informant says that George has an I.Q.[1] of 155. This means that he does as much on a mental test as the average youngster 55 per cent older than he. Since he is nearly eleven, this means that he has a "mental age" of about 17. She adds that he is the highest in two classes. She might have gone further. In the original group of 905 unselected school children which Terman used to restandardize the Binet-Simon tests, not one had an I.Q. of over 145. But afterwards, in his search for gifted children, Terman found a good many

[1] For the sake of readers who may not be familiar with the term, it may be well to explain that "I.Q." means "intelligence quotient". It is the figure you get when you divide a child's "mental age" by his chronological age to two points of decimals and multiply by 100 (to get rid of the decimals). Since George's chronological age was "almost eleven" and his I.Q. was found to be 155, his *mental age* must have been about 17. To say that a child has a mental age of, say 5, means that he does as well on a Binet-Simon test or one of its revisions as an average five-year-old. George, with a mental age of 17, must have done as well as the average seventeen-year-old. Usually a person's I.Q. remains about the same as he grows older. A mental age of 6 at five points to a mental age of 12 at ten, and possibly something like a mental age of 18 at fifteen, the I.Q. remaining 120 all through. But brains do not keep on increasing with one's years indefinitely. After about 16 the conception of mental age tends to break down, and adults are measured by scales based on another principle, such as the army Alpha.

with higher I.Q.'s than George's. About 177 California children out of 128,600 equaled or excelled him. This means that George is one out of 726—in California. But California ranked high in the army tests, so let us say that in the country at large he is one out of a thousand.

This does not look very much as if George could expect to be what Galton called "illustrious"—the outstanding man in a million or in many millions—at least on the basis of his general intelligence alone (which is all that an I.Q. is meant to estimate); though with health, training, opportunity, and the right emotional attitudes, he might very well hope to become "eminent" (one of the best 250 in a million). Indeed, for all we know, he may become very eminent; for we do not know how many of his gifted competitors are destined to fall by the wayside, or how far these other factors may go to make native gifts effective.

We get further light on his prospects from the tables in Catharine Cox's *Genetic Studies of Genius,* Volume II: *The Early Mental Traits of Three Hundred Geniuses.*[1] With inexhaustible patience, Miss Cox gathered every available scrap of information about the early traits of three hundred geniuses (men other than royal personages to whom the most space is devoted in biographical dictionaries), and then invited two other skilled mental testers to join with her in guessing, on the basis of the juvenile records, at the I.Q. that each of the three hundred would have received if he had been given a standard test in childhood. Usually there was a close agreement between the three independent estimates. But, of course, the scores are generally too low, for nobody knows that the brightest things recorded were the brightest things done by these youngsters of an earlier period.

It is evident from Miss Cox's lists that in mental ability George is hopelessly outdistanced by the juvenile John Stuart Mill and Sir Francis Galton, to each of whom is assigned an I.Q. of nearly 200, Goethe (185), Macaulay (180), Voltaire (170), and J. Q. Adams (165). He is beaten by Pope (160), and probably (for the reason given) by Tennyson (155), Samuel Johnson (155), Wordsworth (150), Scott (150), and Byron (150). I mention only some of the more familiar

[1] Stanford University Press, 1926.

names. But on the other hand his general intelligence may well rank higher than that of the boys who became Sir Francis Drake (105), Bunyan (105), Copernicus (105), Faraday (105), Captain Cook (105), Raphael (110), Cromwell (110), U. S. Grant (110), Luther (115), Cortez (115), John Adams (120), De Foe (120), Farragut (120), Sherman (125), Lincoln (125), Washington (125), even when a liberal allowance is made for the things that we do not know about the youthful achievements of these last. So our hopes for George go up, *if*, when his time arrives, he has had adequate training and can show those qualities outside of pure intelligence that are also essential for success. On the basis of her studies, Miss Cox finds these to be persistence of motive and effort, confidence in one's own abilities, and great strength or force of character. But are not these the very qualities that our teachers are, or should be, trying to build up with their projects, researches, and group enterprises? Bold educational thinkers know that the education of youth is a problem in dynamics—teaching a youngster to attack the world courageously and wholeheartedly and to profit by experience, until at last, if he is lucky, he finds ways of acting that give inward harmony no less than outward "adaptation" and efficiency, and thus solves the problem of living.

But here is a difficulty that cannot be evaded. However bold educational leaders may be, teachers themselves are often a timid folk who do not catch the full import of the principles they have been taught, and who, moreover, are biased by the necessity they are under to maintain the organization of their schoolrooms and to show results to supervisors of various subjects, as well as by the old-fashioned ethical conceptions from which most of us grown-ups have not yet entirely freed ourselves. We were brought up to believe in virtues to be attained and vices to be expelled, as if somehow or other these were assorted things within us whose mere presence was in some way good or bad. Consequently, when it is said that our boy is afflicted with "selfishness" or "laziness", we cast about for means of expelling or "overcoming" the vice, instead of going right ahead and helping him to grow and conquer his world, in the faith that when life as a whole is vigorous and well-directed, details can take care of them-

selves. And so with some of our teachers. Their moral philosophy has not been completely reorganized to match their professional training, and consequently they are puzzled and distracted, perhaps sometimes a little panic-stricken, by words that suggest something listed as a vice instead of a virtue.

It is no wonder. For the contrast between the old moral philosophy and the new post-evolutionary and post-Freudian conceptions is fundamental and far-reaching (which is very far from saying that modern psychology leaves no place for morals at all, as some libertines would like to believe).

Biology has taught us to look at life from the standpoint of a struggle for existence and a constant adjustment or readjustment of the whole living being to his material and social environment. If George is called selfish or lazy, there is a maladjustment somewhere, which it may or may not be worth while to try to correct, perhaps by changing his mother's expectations. But you will never get anywhere by trying to squeeze "selfishness" out of the boy. There is no such thing within him. The word only marks a phase of outward conduct. The real things to look for in your efforts to improve him are of quite another nature—his amount of vital energy, his instincts, habits, established loves, hates, and fears, his inward conflicts and repressions, his integrating and dissociative trends, his capacity for self-analysis, his general intelligence, his special gifts and incapacities. Here is the real driving force, here are the mechanisms (or some of them) that determine how it is spent, and here is the place to apply appropriate remedial measures if things go wrong.

And the aim of all such measures is not so much to produce any standardized type of character marked "approved" to begin with, or any special array of virtues. Rather it is to perpetuate, strengthen, or restore one's original satisfying sense of belonging to something larger and better than oneself (with all the mutual respect that that implies), and to adapt that sense of social unity to the needs of a growing, self-determined, responsible personality. It is to remove needless weights of fear or prejudice and the childish ways and weaknesses that so easily beset one, so that the child may run with unfaltering, wholehearted endurance the race that is set

before him and win the prize of his high calling—that achievement of his destiny, that sense of victory and repose, that service with perfect freedom, which come when there is harmony of impulses within and active adaptation to the world without, no matter whether the person is quite like anybody else or not.

Note how functional, how throbbingly vital it all is; how the sharp lines disappear, as they do everywhere in nature; and how puzzling, perhaps shocking, such a conception of life and morals must be at first to a timid, custom-bound soul full of taboos, with Decalogue conceptions of catalogued rights and wrongs and stereotyped plaster-saint notions of virtues; as puzzling and shocking, perhaps, as those teachings of old to which we seem to be returning: "The Sabbath was made for man, not man for the Sabbath." "Neither do I condemn thee; go and sin no more." "I have come that ye might have life and have it more abundantly."

And now to come back to the "selfishness" that some of our teachers read into George's character. The word stands for an outer maladaptation. Selfishness is not an inner force or state or act or feeling. Some of our teachers, to be sure, like many other people, identify it with self-absorption. A selfish person, they assume, is always thinking about himself. But that is not necessarily so. George may "selfishly" forget some errand, not because he is thinking of himself, but because he is thinking of Theseus or Captain Kidd, just as you yourself may be so absorbed in some spectacle that you entirely forget yourself, your manners, and the person behind you. That may be selfish, but it is not self-absorption (however true may be the converse that a thoroughly self-absorbed person is bound to be insidiously selfish, even when he is priding himself on his self-sacrifice). Neither is selfishness the lack of some specific form of habitual conduct that can be worked into a person by the proper kind of training. If you can train a dog to sit up and bark for food, why can't you also train a child to lend his toys, mind his mother, learn his lessons, and give up his seat to a lady? Well, you can. But what you get from it all is a repertory of good manners (valuable enough for anybody if they don't absorb his life), but not unselfishness. For every one of such trained per-

formances may or may not be selfish according to the conditions under which it is used.

The heart of the matter lies deeper. To be selfish is to fail to pay due regard to the interests and true well-being of other people. But what is due regard? Is there no difference between their interests and their whims? Are those now about you the only "others" to be considered? And how about yourself, your own future, and your own present living? How much should they count? No two answers to such questions would be entirely alike. Reasonable unselfishness is a matter of attitude and perspective; and how can you expect very much in the way of perspective from a boy who is eagerly "learning his world", a bit at a time? As to the attitude, there is all the difference in the world between vitalizing human sympathy that flows out of the abundance of joyous living on the one hand, and cramped self-abnegation, fear, and malice on the other, no matter what kind of surface conduct these qualities accompany—till something breaks.

If you want any kind of valuable human relationships from George in later life, you will try to keep alive not only his own self-respect and his respect for the rights, interests, and dignity of other people, but also his sense of human fellowship in victorious adventure. This can't be done by nagging or by constantly breaking in on the things that he thinks important or by exploiting his kindly impulses, keeping him tied to his mother's apron strings, or trying to lead his life for him. The frivolous saying that the black sheep is often only the goat agrees entirely with the findings of experts who assure us that the problem child is often the most normal member of his family. Few things can do more to produce self-absorption, discouragement, moroseness, the distortion of values, and the killing of healthy interests than inconsiderate attempts to cure a healthy-minded independence that some one has discovered to be "selfish". If you want to help George, don't think about his "selfishness". That is a fatal approach. Find out whether his whole attitude to life is healthy and happy (for they go together), and when it comes to some specific thing that he may fail to do, try to find the reason. You may conclude that getting him to do it

would not be worth the price: "Wist ye not that I must be about my Father's business?"

And so with "laziness". To call some one lazy means that you disapprove of him because he does not do all that you desire, but beyond that it tells nothing whatever about him. *Why* won't he perform? Is is because his thyroid is not working, or because he is anæmic or fighting germs or depleted in some other way, and has not physical energy to do much of anything? Is it because the particular things that you want done don't seem to him worth doing, though he is glad to read and dramatize and work out problems? Is it because he thinks it beneath his dignity to do them, or to take suggestions from any one? Is it because a solicitous mother seemed to him just fussy and got him into the habit of ignoring the demands of other older people, or even because he has developed a secret hatred for her or for anybody like her and actually gets malicious pleasure out of the futile efforts of others—especially perhaps of women—to control him? Is it because something in his personal or family history has left him feeling disgraced and hopeless, in spite of his brains, and no effort seems worth while? Or is he full of deep, paralyzing conflicts that it would take an expert to uncover and remove, or so absorbed in daydreams that he finds it hard to attend to anything around him? There are many different conditions that might provoke an accusation of "laziness", no less than of "selfishness", and, in spite of all that we used to hear about the thrashings that laziness deserves, they all require a different treatment. If you want to know what (if any) of all these different kinds of laziness can justly be charged against George, go back and read the concrete details of the story.

In any case you must avoid the blunder of mistaking "laziness", "cruelty", "dishonesty", or any other such social maladjustment for the inward force or feeling that helps to bring about the objectionable response, and remember accordingly that there is no such thing as impressing or removing isolated virtues and vices. You are dealing with a whole living organism, an individual striving to coördinate his interests, win his way, and maintain his self-respect. Growing things are not to be molded on a potter's wheel, and decent self-respect cannot be given with his pattern by the potter.

With virtues and vices for their own sakes well out of the way and our thought firmly fixed on the problem of rich, victorious, whole-hearted living, let us return to George and the problem he presents.

He is said to be "introverted". This is a new word in psychology, and how ominous it sounds! Hamlet was an introvert, forever dreaming and planning and never doing! Introverted also are many poor creatures in insane hospitals who are there because they can't turn thought into action. But then *any* man of thought rather than of action is called introverted, too—the student, the philosopher, the poet, the logician. So far as George is concerned, it may be that he lives in a world of books because he is afraid of real, live people, or can't get along with them, which is bad; or it may be that he isn't really introverted at all, but only absorbed in books because they stimulate his thinking as the people around him do not. At least he seems to have a very healthy way of bringing the fruits of his reading back to his classroom work—which is not so bad, in spite of the big word. Most bright children do "too much" reading.

And don't forget that George is eleven in age and a good deal more in brains. May not both the "laziness" and the absorption in his books be due in part to the beginning of an adolescent drive for big adventure in a larger world, free from the restraints of childhood and from the platitudes of interfering elders? If this is it, will homilies about his heroes drive him from Lincoln, Edison, and Roosevelt to others who aren't so respectable—for example, (if he is lucky) to Benvenuto Cellini or "The Three Musketeers", those magnificent scoundrels that no teacher would dare to hold up as models? Or if, for his sins, he is kept away from books and dramatics altogether, is there a chance that he will find his thrills in the company of some gang that will only do him harm, or that he will lose his soul entirely in unhealthy brooding? If the great heroes of history and literature will tide gifted budding youth over a period of instability and leave an interest and perhaps an ideal for later years, they serve a useful purpose, even if they don't make the boy do various simple tasks. If King Alfred hadn't been "self-absorbed", "selfish", "lazy", or "careless" enough to burn the cakes, would he ever have won or saved his kingdom?

Our great trouble in prescribing for George is that we know so little about him. What is his history, his physique, the state of his health? Who are his classmates, and how does he get on with them? What about the neighborhood, and the family? Has he no brothers and sisters? For "being an only child is a neurosis in itself".[1] And how about his father? Is he dead or only negligible? It is rather futile to treat little symptoms of good or bad adjustment when we know nothing whatever about the big relationships and the big inward drives behind them. Yet this is what teachers generally have to do, so let us go back and look again at the measures they suggest.

Many of our teachers give tentative answers; they would "try" this or that. Nothing could be better. Even when one knows far more about his "case" than any of us know about George, that is the only sound method.

"Take away his books till he comes up to the mark in other things"? But what if he never does? Would you keep Raphael from painting for the sake of arithmetic and handwriting? We have already discussed the dangers of such a policy. And, too, we must not forget how easy it is for an adult to go back and learn schoolroom tasks when he sees the need for it. As for depriving him of his place in dramatics, and so forth, do you make a person more socially minded by taking away, or taking the heart out of, the social activities that he is already fond of?

"Make him see that in life we must do many things we don't enjoy, or please others rather than ourselves"? But what if he should ask: "Why start anything so dreary until I have to?" And, really, does your statement always hold? Have men of mark usually won their place by sacrificing their major interests to things that bore them?

"Shame him into being less lazy and slovenly"? But what if he tells you that he is neither lazy nor slovenly in things that really matter—*i.e.*, in his reading, theorizing, reporting, dramatizing? And if you do succeed in shaming him over

[1] So said G. Stanley Hall. J. A. Hadfield, however, says: "It is a curious fact that although so much is said about the abnormality of the 'only child', in our experience we meet with very few only children amongst our patients. They suffer more from defects of character than from nervous disorders, for they have usually been brought up in one atmosphere, with one phantasy of themselves. (In *Psychology and Morals*. New York: Robert McBride and Company, 1925.)

the lesser things, will it kill his zest for the greater? And then, too, what about the chance of wounding him more deeply than you intend? Shame paralyzes oftener than it stimulates, and it is easy to get the habit of feeling that somehow you are fundamentally wrong.

"Try to make him like me well enough to start doing things for me, personal things at first and school work later"? Such a method, kept free from sloppiness, would be especially useful for George if his mother and others have been making him a little edgy. Even if it involves some subtle sex appeal, it is not a case of "vamping", for the vampire plays on one's affections for her own selfish ends. Any woman, now or later, who teaches George to sublimate emotion, and work (in part, at least) because he loves or admires, will do him a lasting service. One *might work* from spite or from fear, and love *might* make one idly bask or seek perpetual cuddling.

Let there be no misunderstanding here. The teacher must not be a mother substitute and keep the boy bound like a baby forever, obediently doing things "for her sake" and then returning, as it were, to her lap. Growth comes from within. Freedom is won, not conferred. But mothers need not cuddle forever, and the teacher can help her pupil to break the association, if there is any, between love and mutual understanding, on the one hand, and a spirit of infantile dependence and obedience on the other. In so far as we are social beings, we seek companionship and a sense of unity. In infancy we are dependent and we get this social satisfaction in conjunction with dependent attitudes. Freudians would say that there is a partial sex satisfaction also. Naturally the social satisfaction and whatever sex satisfaction there is get confused with the dependence, and in so far as they fail to get differentiated afterwards, love, friendship, and mutual understanding must continue to mean to the boy dependence, the consequent chronic inhibition of all initiative and self-asserting drives until they are approved by some superior person—and, therefore, spoiled—and the sense of martyrdom that such a perpetual attitude of subjection inevitably involves. For the rest of his life he may remain loving, dependent, "good", and martyred. He may break loose and be hateful, vicious, and maliciously triumphant. He may

alternate, with occasional wild rages interrupting his docility or with intervals of extreme docility interrupting a usually hard-boiled career. He may develop a double personality. He may spend all his life vacillating. But whatever he does, the root of all the trouble may be the infantile identification of kindly attitudes and mutual understandings with dependence and submission; and a teacher who has won his affection can help to break up this vicious association by applauding initiative when he displays it and helping him to develop wholesome standards for independent judgment. "None but the brave deserves the fair", and lingering infantile dependence does not make for bravery.

"Give him sympathetic understanding"? He probably needs it. A youngster with the mental capacity of a seventeen-year-old, but the physical development, the emotions, the experience, and the social surroundings and obligations of an eleven-year-old is pretty sure not to be understood. His mates doubtless laugh at his "queer" ideas, while, as we have seen, grown-ups get anxious about him. He can easily get an unhappy sense of being "different" and apart, to dog him for years. But don't forget that understanding comes hard. It is more than mere kind feeling. It means continually putting yourself in the other person's place and patiently figuring out his attitudes—no easy task if he happens to beat you in brains, is of the other sex, and is getting his first impressions of life in this new world that didn't exist when you were in the making.

"Make myself interested in what he does and ask to be shown his difficulties"? "Show him well-written papers and say that I have confidence in his ability to do as well"? Here are fruitful suggestions. Don't treat him as a moron. But how about something like this? "George, if a word is hard to spell, it is because it has had an interesting history. Don't leave that 'b' out of 'doubt'. It comes from the Latin 'dubitare', the same root that you find in 'dubious', though it managed to pick up an 'o' somewhere or other before the Normans brought it to England." Or this? "George, there is as much reason for a particular kind of bad handwriting as there is for any one's bad work in basket-ball or tennis. I think I have found out something about yours, but I am not

sure. Let us ask the supervisor to help us." Why not make George see that we can solve mechanical problems by thinking, and use his very difficulties to give him the wider perspective that he enjoys? Is that not education? And if you yourself do not happen to know about words or the mechanics of writing, what a chance for you and George to engage in coöperative research!

"Appeal through his heroes, emphasize the qualities that he must develop to be like them, say that their aim was to serve", and so forth? There are several difficulties here. The lives of heroes are not so simple as all that. Some of their qualities were abominable, the very opposite of those that his rather conventional teachers want George to develop. Again, as we have seen, that whole point of view is too static. People do not become heroes by having a ready-made list of admirable virtues, but by doing things successfully; and until one knows what has to be done, it is not much use to load up with the virtues. They may not be the ones demanded when opportunity knocks. Finally, it is a fearful thing to oppress a child with the burden of becoming a hero. In the present it kills spontaneous, self-forgetting interest, and for the future it generally means overstrain, false perspective, and a deep sense of failure. Wouldn't you get further by just enjoying his hero stories with him if he wants to talk, and by leaving them alone altogether if he doesn't? Let the boy have some sacred possessions.

"Assume that he's all right and leave him pretty much alone"? A much safer policy than to assume that he's all wrong and be always trying to save him, and splendid advice for his mother and all other anxious elders, for it makes a vastly healthier atmosphere. Being comfortable when he is around is not a bad way to influence any one. But that does not mean that nothing whatever can be done to help him realize his possibilities.

"For the sake of his health get him out-of-doors—playing, making things with his hands." For mental health as well as physical. Books are a new element in human environment and so is the sedentary, solitary business of reading and writing; but "the great out-doors", the give-and-take of playful contacts with one's fellows, the need and the urge to use one's

big muscles and make things with one's hands, go away back to, or toward, pre-human times. To be without them is to miss half the joy of living, and a life that is not at home with them is not always secure, as notable breakdowns show. Refinements of thought and action are most secure and lasting when they *are* refinements, or more precise adaptations of, vigorous, natural, rough-and-ready activities. So by all means do what you can to make George at home and effective in all these fundamental relations. It does not hurt a brain to grow on top of bone and brawn. It must be remembered, too, in this connection that life is much longer now than it used to be. We must plan for a serene and balanced old age.

"Make him earn money for the things he wants, and perhaps for some of those he needs"? Why introduce this complication? To cure his "laziness" and bring him to time? But at what cost? If none of his friends are working and it is not really necessary, will he feel inferior and put upon? Will it take time from better employments and kill the healthy outside activities we have just discussed? Will it give him an undue sense of the value of money and thus tend to ruin or pollute his career? George isn't going to be a grocer's clerk; and he is neither a moron nor (apparently) a spendthrift who must earn some pennies in order to learn how many of them it takes to make a quarter. But he is a gifted boy, who can gain much from the experience of others if he has the chance, and who can learn to see things in the large and work from general principles. Don't try to put too old a head on his young shoulders and waste his time in some blind-alley job. If he must be tied to routine, why not let it be that of his school fundamentals?

"Make a social appeal through his mates"? Rather, do what you can to enrich and normalize his social life. Two things must be remembered: that the commonest and most serious maladaptations are social, whether they are manifested in a mild "inferiority complex", in crime, or in a downright psychosis; and that when a youngster starts to go to school, moral authority begins to be transferred from his parents to his mates. It is our contemporaries, not our doddering elders, whose admiration we grown-ups seek, whose scorn we fear, and with whom we want to feel at ease. It is

thus of great importance for morals and sanity and comfort that the boy should learn to get along with his mates, earn their respect, and prove his capacity to them. In the long run, that should help even the handwriting. But social adaptation is more important than school studies and should not be sacrificed for them. The unsocial or antisocial attitude of many insane people, with the disregard of every decency that often accompanies it, shows what may happen when social pressure is overdone and the victim feels that it is hopeless or useless to try to live up to demands and expectations. You will notice, however, that on the whole our teachers avoid the danger. Not through scorn and ridicule, but through the drive of healthy coöperation, stimulating responsibility, and happy leadership would they have George master the boresome details of his work. Is not that the answer to those who say: "Children must be taught to do disagreeable things"? Not at all! They must be so taught that the disagreeable is transformed into an element of good by the place it takes in a happy whole. Only when the big determining drives are blocked is life "one damned thing after another".

"Fit the boy's school work to his intelligence"? Of course. But how? A much higher grade means older classmates, bigger, stronger, more mature, and more experienced, to put him at a social and a physical disadvantage. And then how about those fundamentals that he has not mastered? Won't he seem like a dunce? Enrich his work, give him books and freedom, and leave him where he is? Not so bad if the teacher is tactful, competent, and willing to do the extra work, though he ought to have stimulating friends and rivals. Put him in a high-I.Q. class? Better than the ordinary class of this sort is one of the special classes for highly gifted children that have recently been established in Cleveland. For the comfort of those who are disturbed about George's "laziness", it may be said that all the children in such classes are lazy—at first. They have never had the spur of competition in a schoolroom to make them work. Miss Cox's studies of great men showed the large part played in their early lives by a gifted teacher. A whole group of gifted people working and playing normally together should be at least as good, though in a somewhat different way.

When all is said and done, it is hard to do just the right thing for any child, even if he be commonplace. We are always bungling. With a youngster brighter than ourselves, it is doubly hard. But then we must remember that most of the difficulties are due to ourselves. We love to mold, control, and standardize, and we want so much to be proud of our children that we sometimes forget God's breath of life that gives all the value to good form or meat or raiment. We forget that the letter killeth, while the spirit, moving where it listeth, maketh alive. We try so hard to protect from faults and blunders that we often leave no room for legitimate adventure and real living. George has brains enough to make pretty big adaptations for himself as he sees the need for them, provided that his initiative is not killed by false taboo and over-criticism, and that in his home there is an atmosphere of peace and confidence and happiness to keep his emotions normal and his judgment undisturbed. "Out of the heart are the issues of life"—of outward achievement no less than of inward blessedness.

SPEECH DISORDERS

SMILEY BLANTON, M.D.
Professor of Child Study, Vassar College

SPEECH disorders can be understood more easily if we review very briefly the functions of speech. From an evolutionary standpoint, speech was developed to express the emotional life. The lower animals use their calls and their cries, which are the forerunners of human speech, to express their fears and loves and rages. The newborn infant has only a few cries that express hunger and pain. The speech area in the brain, present in every normal person, is on the side of the brain opposite the preferential hand and is not yet developed.

Now, since speech was developed to express emotions, the speech mechanism is most sensitive to all emotional changes, both conscious and unconscious, and it is not hard to understand how feelings of fear or timidity or inadequacy easily influence this speech mechanism, which extends all the way from the pelvis to the top of the head and includes more than one hundred muscles. Emotions even of a slight character will often interfere with the delicate coördinations necessary to speech and cause hesitancy, blocking, or a real stutter.

Every person is tied within himself and is always pathetically trying to express himself to other people. The chief way in which this expression is accomplished is through the extraordinary faculty of speech. It is through speech that we come into contact with other people. It is sometimes said that there is too much casual conversation—that people ought to talk about weighty matters, such as the League of Nations, prohibition, or the function of philosophy. In ordinary conversation a person will say, "It is a nice day", and his neighbor may reply, "Yes, but we had some rain yesterday." Those who feel that we should not have this casual conversation are usually suffering from feelings of inferiority. It is the experience of mankind that it is unwise, in casual contacts, to introduce controversial subjects. Weather is a safe subject

for casual conversation. The real reason for casual conversation is not to say something weighty, but to express to our neighbor a certain attitude of friendliness and understanding. We give a glimpse of our personality when we speak. A friend passes and says, "Good morning. How are you?" We reply, "Fine!" Nothing of importance has been said, and yet we feel that we have touched hands with some one, psychologically, as we pass.

Speech, then, is the chief means through which we come into contact with other people. People who feel timid, insecure, inadequate, or inferior when they have to meet other people—when they have to meet the group—are likely to hesitate or block or have a real stutter. The real cause of stuttering can be understood when one remembers that speech is a means of adjustment to the group, a means of expressing the emotional life, and a short cut to action; these are the three functions of speech. If these three functions are kept in mind, speech disorders are easier to understand.

There are a great many ways of classifying speech disorders; some books give forty or fifty classifications. We have tried to formulate a purely descriptive terminology which is quite tentative. Its advantage is that it helps us to get away from an involved and complicated terminology and to look at speech disorders from a behavioristic standpoint. This classification is:

1. Delayed speech.
2. Letter-sound substitution.
3. Oral inactivity.
4. Stuttering (including stammering).

1. *Delayed speech.*—The normal child begins to talk at the age of about fifteen months. Parents frequently say that the baby is talking at nine or ten months. At this age the child is passing through the babble stage, in which he is repeating the words that he hears, but this is not speech. It is not until the baby is about fifteen months old that he begins to speak—that is, to use words with meaning. During the babble stage the child may say, "Mama, mama", in an aimless way, but when he begins to speak he says, "Mama", when his mother comes into the room or when he wishes his mother.

In training the child to talk, it is better to use words only in the situations in which they belong. We often see people foolishly hanging over the baby's cradle and saying, "Bye-bye, bye-bye!" when they are right there. "Bye-bye" should be said to the child only as you are going away. We were able to train a baby to say the word "milk" and respond to that word at the age of ten months. Every time we presented the bottle to the baby, we would say, "Milk! Milk!" half-a-dozen times and give him the bottle. The child got the meaning of the word after about a month's training.

If the child is not talking by the time he is two years of age, he should be carefully examined. Prolonged illness or rickets may delay speech for a few months, but if the child's speech is delayed much beyond the age of two years, the matter should be given very serious consideration.

The five common causes for delayed speech are:

A. Lack of mental development.
B. Prolonged illness during infancy.
C. Deafness.
D. Lack of necessity for speech.
E. Extreme negativism or hysterical condition on the part of the child.

A. Lack of mental development.—In this case the fundamental reason for delayed speech is an undeveloped brain. Dr. Tredgold points out in one of his lectures that of the five or seven layers of the brain, it is the upper two or three layers that have to do with the intellectual processes. These upper two or three layers of brain cells are the last part of the nervous system to be developed; hence they are very delicate and liable to injury. A very slight injury to these upper layers of brain will cause a delay in the highly specialized function of speech. A child may grow up a moron—an individual with a mental age of from 8 to 12 years—and still have a brain defect that will delay the development of speech.

Some of the causes for this injury to the brain are hemorrhages at birth or infections of the brain. These cases of delayed speech frequently present a very puzzling picture. If the child is not talking by the time he is two or two and a half years of age, he should have a very careful test to

determine his mental capacity. Dr. Gesell is now developing methods for testing the mental capacity of the infant.

B. Prolonged illness during infancy.—Prolonged illness at the period when the child is developing speech may often cause the speech to be delayed. I recently saw a child who had had an attack of pneumonia at the age of fifteen months, and after that an infection of the pleura around the lungs which lasted for four months. The child had to have two operations in order to drain the pus from the chest. This child did not develop speech until the age of three years. Now, at the age of five, the child's speech is quite normal.

C. Deafness.—Even a slight deafness will interfere with the development of speech. The deafness may be so slight that it is not noticed, and still it may prevent the development of speech at the right time. If children do not hear perfectly, they are not able to make the fine coördinations of speech at the usual time.

D. Lack of necessity for speech.—Man has the capacity for speech, but he does not develop speech unless there is a definite need for him to do so. The majority of persons assume that speech is an inherited process, and apparently think that under any type of training the child will develop speech. It often happens, however, that the brilliant, overemotional child with an overactive nervous system does not develop speech at the right time because he has no need to develop a short cut to action. Everything is done for him and there is no need for speech. Such a child will utter some jargon like blub-a-blub-blub, and the family will interpret these unintelligible sounds and give the child what he wishes. Many, many children do not develop speech at the right time because there is no need for developing it. Not infrequently children are cared for at the age of four years in the same way that the young infant is cared for. Their every wish is satisfied. Of course they do not develop speech. Such children should be made to ask for what they want as plainly as possible before their wishes are satisfied.

The fundamental training for such a condition is not phonetic training, but the systematic and diplomatic supplying of motives for developing speech. Give the child a chance to

hear good speech plus an active impulse for acquiring it, and the child with a normal brain and nervous system will develop speech.

One of the difficulties that we encounter in giving phonetic training to such children is that the parents know so little about the English language. They do not realize that there is very little relationship between written and spoken speech. Phonics, as used in some public schools, have often given rise to speech defects.

In training the child to speak, we must realize that we speak not in written words, but in phonetic words. "Iamgoingdowntown" is one phonetic word just as much as "Constantinople" is one word. Parents, however, in training children with delayed speech to speak, often ask the child to say, "Bread *and* butter", or, "Cup *and* saucer". In training the child to pronounce the words in this way, they are teaching him to speak in a way that is not normal. When we speak, we do not say, "Bread *and* butter", we say, "Bread'n butter". In training the child at first we should use only single words, such as bread, butter, milk, saying the words as we present the thing to the child. Instead of using this method, I recently heard a mother teaching her child, who was delayed in speech; she said, "Now, darling, say 'milk' for mother." It was of course impossible for the child to apprehend which word he was to repeat.

2. *Letter-sound substitution.*—Letter-sound substitutions are defects in which one speech sound is substituted for another. The most common of these sound substitutions, known as the lisp, is the substitution of *th* in the voiced or voiceless form for *s* or for *z*. For example, the child will say "Thimple Thimon" for "Simple Simon".

Some people maintain that lisping is caused primarily by the fact that the jaw is deformed. There is only one type of jaw deformity that is certain to cause lisping—when the lower jaw protrudes beyond the upper jaw, there is bound to be a slight lisp. Of course, children have a lisp when they lose their baby teeth. If the teeth are in, the child can be taught to manipulate his tongue in such a way as to sound the letters unless he has a protruding jaw. Most lisping is

a type of infantilism. The child continues talking in this infantile way because he knows it ties him to his infancy. The child does not wish to detach himself from his infantile surroundings. It is a bond between him and his early environment.

In one of her lectures, Mrs. Blanton gives the following illustration: "A woman of thirty came to us with a simple substitution of *th* for *s*, an extremely common type of infantile substitution. She wished to enter the work of speech correction. In conferring about her qualifications for the course, we discovered that she was already doing platform reading of a high order. When we asked her to read for us, in order that we might see how much her letter-sound substitution interfered with her platform work, we discovered that she read without a trace of this substitution. We asked her why, in platform work, she should throw off this substitution while retaining it in her everyday speech. Her answer, with a distinct lisp, was: 'My father likes me to talk this way. He says it is sweet and that I am still his little girl.' " This attitude, while more frankly stated and more conscious with this woman than is usual, is the customary, conscious or unconscious, attitude of the lisper or of the person who makes the simpler substitutions. This clinging to early childhood and the unwillingness, in at least this one respect, to grow up is the fault; rarely is there any lack of ability to make the sound. Every person of good intelligence who retains a faultily made simple English consonant in adult speech certainly suggests infantilism, and especially is this true if he minimizes the importance of eradicating the defect.

Other types of letter-sound substitutions are as follows: *s* becomes *th* or *sh* or voiceless *l* or voiceless *n* or voiceless *r* or the glottal stop; *sh* becomes voiceless *l; r* becomes *w* or *v; l* becomes *w; th* becomes *w* or *d* (voiced); *th* voiceless becomes *y; y* becomes *r*.

3. *Oral inactivity.*—Oral inactivity may be defined as a slurring or indistinctness of speech. It may be an inactivity of the jaw, the tongue, or the lips. This difficulty is caused sometimes by a paralysis of the vocal organs or by a lack of development of the tongue. It is very uncommon, however,

to find any obvious weakness of the tongue; but apparently there is a certain lack of muscular development of the tongue which prevents it from making the quick, accurate movements necessary for speech. It has been estimated that during one minute of speech the tongue makes from five to six hundred movements. It is easy, therefore, to see what a high degree of development the tongue must have in order to make these movements easily and smoothly. Just what is the cause of this lack of tongue development is not known. Apparently rickets has something to do with it. We find such cases very often in children who have rickets, and we feel that there is some relation between rickets and the lack of tongue development. Inactivity of the lips and tongue is very often caused by an emotional attitude of timidity. It is not infrequent to see timid or sensitive people who keep their lips together when they talk or who do not move their jaws, so that their speech is not clear.

The cases of oral inactivity caused by some lack of development of the speech organs or by paralysis of the speech organs require very careful training in corrective phonetics. The cases of inactivity of the lips or jaw caused by emotional attitudes should be treated by means of a careful reëducation of the emotional life plus some speech and voice training.

The training in corrective phonetics must be carried on very carefully. If the child is pushed too hard, if he is made too self-conscious of his speech organs, already weakened as they are, he may develop a stutter. I have seen many children with an oral inactivity change into stutterers because the phonetic training was unwisely given. One thing that should never be done is to teach such children to carve every word before they let it fall. I recently saw a tragic case of a boy slightly deaf who had a marked oral inactivity caused by this deafness. He was quite a bright boy, but because of his peculiar speech, people who did not know him thought he was feebleminded. When he reached high school, he came across an elocutionist who taught him to sound every word. The result was a speech defect worse than his oral inactivity. He would say with marked hesitation between each word. "Good ——morn——ing, Doc——tor. This —— is —— a —— ver—y —— nice —— day —— is——n't it?"

4. *Stuttering.*—This is the most interesting, but difficult speech disorder with which we have to deal. It comes almost entirely within the province of mental hygiene. Up to the present time, however, the stutterer has been fair game for all of the quacks in the country. Since stuttering is an emotional difficulty and sometimes yields to treatment by suggestion, almost any quack will get results in some cases. A very interesting example of stuttering cured by suggestion is that of a little Italian girl in one of the schools in the Middle West. When she first entered the speech class, the teacher found that she slept with her window down. She thought she would start out by giving the child a good physical-hygiene program, and said to her, "Mary, if you want to get well, you must put up your window at night." Mary came back next morning and said, "Teacher, I'm well." From that time on she talked without a stutter. This does not mean, of course, that all stutterers can be cured by asking them to open their windows at night. We would hardly be justified in founding a school on this method of treatment.

Stuttering is common enough in children to constitute a very serious problem. It has been estimated that about 1 per cent of children stutter. This means that in the United States there are perhaps 200,000 school children who stutter. Since the intellect and the emotions of the child develop very largely through speech, a speech defect will tend to slow up the development of the mental life. Stuttering manifests itself in many ways. In some individuals it shows itself in broken spasms of the vocal cords in which there is a repetition of the initial letters or syllables; in others there is a tonic spasm of the speech organs, causing a complete blocking on various words. The spasms are not only different in each individual, but they vary from time to time in the same individual.

The situations that give rise to symptoms of stuttering are quite different in individuals. An explanation of the cause of stuttering is not to be found in our examinations of the bodily organs. The cause of stuttering must be found through a search of the emotional life.

It is interesting to find out the age at which stuttering begins. We studied four hundred cases of stutterers, the ages of the cases varying from eighteen months to thirty years.

The majority of the four hundred cases began at the age of two and half years. There is another peak at the age of six. This is the age when most children start school. Two and a half years and six years are the two periods at which stuttering most frequently starts. These two ages correspond to the two great breaks in the life of the child. Between eighteen months and two and a half years the child has to break away from his infancy and take his place as a member of the group. The first time that the child has to break away from the home and adjust himself to people outside is at the school age. It is at these two ages, then, that we find stuttering most frequently beginning.

We have spoken of the fact that speech is the chief way in which we adjust ourselves to other people. Stuttering is a symptom which indicates that the individual is unable to make this adjustment. Stuttering is a symptom that expresses a lack of adjustment to the group. We are all trying to adjust ourselves to other people. When we can do that, we are well adjusted. When we cannot, we are unadjusted, unhappy, and sometimes mentally sick. In stuttering, this adjustment to other people through speech is broken down, and instead of having normal speech, the speech is inhibited and broken. Stuttering, then, is caused by fear, partly conscious and partly subconscious, of meeting the group.

The situations that give rise to stuttering vary considerably in different people. Some people stutter only when they make a public speech and other people do not stutter in such a situation; some stutter with their parents and not with their teachers; and some stutter with their teachers and not with their parents. The emotional reactions that give rise to stuttering are, therefore, quite subtle. The emotional difficulties that give rise to the psychoneuroses are very much more exaggerated and marked than are the emotional difficulties that give rise to stuttering. A search into the emotional life of stuttering children always reveals some of these emotional attitudes and conflicts—timidity, feelings of inferiority, overdependence on the parents, and the feeling of general inadequacy. Often we notice a marked rigidity toward life, an unwillingness to change food and sleep habits. Again

we find an oversuggestibility, a chronic fear of meeting certain groups of people or situations, and a marked sensitiveness.

It has been claimed that these emotional difficulties are the result of stuttering and have nothing to do with its cause. A study of the personality of stutterers, however, shows that their emotional attitudes are primary and are the cause of the speech defect. Stuttering may accentuate emotional attitudes, but it does not cause them. The essential characteristic of the temperament of the stuttering child is a marked sensitiveness to social situations. This sensitiveness is really a great virtue if properly trained and controlled. In my own experience with stutterers, I have come to feel that they have the most pleasing and delightful personalities of any group with which I have come in contact. Their quick responses to social situations, their marked sensitiveness, and their keenness of perception of social relationships give them an insight and develop a type of personality that is pleasing and appealing. Stuttering should not be thought of as something that is wholly bad. It should be thought of more as a danger signal which indicates that the child requires very careful training in order that he may properly utilize a sensitive, over-reacting nervous system.

It will be helpful, I think, to describe several cases of stuttering to illustrate the various types. The first is that of a little boy now about three years of age. He is very intelligent. He began talking at about fourteen months, and by the time he was two years old he had quite a large vocabulary—about as large as that of an average child of four years. Living near were three grandparents and four aunts. The family, of course, was very proud of the child's precociousness. They took great pride in showing him off to the neighbors by having him say rhymes and repeat long words. The child was constantly trying to live up to the expectations of his relations. He became quite nervous and excitable. One day when he was trying to recite a rather difficult poem, which his mother had taught him, for some neighbors, he broke into a stutter. This child's attitude was very much like that of the professional golfer who feels that his reputation is at stake every time he enters a match. This child was practically playing in a speech tournament all the time. The treatment consisted

of having the family and the relatives avoid asking him to repeat long words or say rhymes. He was given a playroom where he could play freely with other children. The pressures were taken from him, and in a few months his speech defect was eliminated. It has not returned now after two years.

Some time ago a girl of three years was brought to the clinic by her mother and father. This child also had a very high intelligence. She was an only child, and the parents were very solicitous about her. They wanted to be sure to train her mind so that when she grew up she would be efficient and successful. Their idea of training, however, was to teach the child a great mass of facts. They had already trained the child to know most of the states in the Union and the capitals of the states. She was being taught a great many facts that should have been reserved for her later years. When the child came in for an examination, the mother said, "Now, Mary, tell us the capital of the United States." Then the mother proceeded to put the child through a quizz. After a few minutes the child began to hesitate in her speech. On being questioned, the mother said that she had noticed during the last month or so that the child had been stuttering quite a little, but she did not think it amounted to anything.

The mother was persuaded to stop this unwise type of training, and the stutter in the child ceased almost at once. It can be imagined how difficult it was for this child to adjust in speech in such a mature way when her fine musclar coördinations had not yet been adequately developed, nor had she the range of attention necessary to master the facts that the parents were trying to teach her. This child, like so many others, was being pushed and made to stand out in an adult group. This is one of the reasons why so many children begin to stutter between the ages of two and four years.

Another case is that of a boy about ten years old with a marked stutter. His family are very intelligent. Both the mother and the father are college graduates, and they intend to have the boy go to college. At the present time he is in a private school, doing very poorly in his studies. A test showed that he had an intelligence quotient of 106, which means that he has high average intelligence, but not sufficiently high to

enable him to finish a college course. He has just about enough capacity to get through high school. At the present time he is a grade higher than he should be for his mental capacity. The family press and urge him continually about his studies. The boy is timid and has a marked feeling of inferiority. He is growing at a very rapid pace at present, so that he appears to be about fourteen years old, and both his teachers and his parents expect him to act like a fourteen-year-old boy. When he acts like a ten-year-old boy, he is criticized. When the boy cries about something, his father will say, "Oh, you act like a baby! Why don't you act like a real man?" He is constantly criticized either at home or at school. Recently the boy brought home his report card, on which he had received *good* in everything but arithmetic. His father looked at the card and said, "Well, you are not good in arithmetic. You can just throw that card in the waste-basket." The boy went upstairs and cried all evening.

During the last six months this boy has developed a marked stutter. It is easy to see the reason why. He is expected to live up to the standards of behavior of a fourteen-year-old boy. He is not infrequently punished harshly at home, and he is not given credit for doing the best he can. The boy stutters worse when he talks to his father. Adjusting to his father is too difficult, and when he tries to do so by means of speech, he breaks down into a stutter.

The most common treatment for stuttering is to give vocal or breathing exercise. It might be asked, "What good would it do to give vocal or breathing exercise to this boy?" The boy should have a chance to talk and read, of course; but the main thing in this case is to get him adjusted in the proper way to his classes and to his family. He is a charming, delightful boy with a nice personality, who can be quite successful if he is not forced to do something that is physically and psychologically beyond his capacities.

Another type of stuttering may be given. This was the case of a college boy who stuttered quite severely. He specialized in chemistry; he liked his work, and was doing very well. A psychological test showed that this boy had a very superior mind. It was only after three or four weeks of daily treatment that we were able to find out what was the

cause of his difficulty. In taking his history, it was noted that he had been always uniformly late in getting his work in, and as a result of this made poor grades. The boy's father is a professional man, nervous and high-strung. He felt that his duty as a father made it necessary to supervise all of his son's activities. He was constantly saying, "Son, don't you think you ought to do this, or don't you think you ought to do that?" As a result of this treatment, the boy had become negative. When his father asked him to do one thing, he always felt the inclination to do the opposite. He carried his extreme negativism with him to college. Unconsciously he transferred to the teachers his attitude toward his father, and when he was asked to hand in a thesis on a certain date, his unconscious negativism prevented him from getting it in on time. Even when he came to graduate, he was unable to get his major thesis in on time and lost his opportunity to graduate in June. He had to wait until the beginning of the next term, which was in September. The boy is now away from home working on his own responsibility, and is doing well. His speech defect is greatly improved, and his negativism, at least in regard to his work, is gradually disappearing. You could not expect, however, to do away with this deep-set feeling of negativism in a short time.

The treatment of stuttering falls into four heads: (a) physical hygiene; (b) mental hygiene, by which we mean emotional reëducation; (c) relaxation, muscular coördination; and (d) speech training. We will not stop to discuss at any length the treatment of physical hygiene. It means, of course, the proper diet, sleep, and exercise. Mental-hygiene treatment consists primarily of analysis of the emotional life and the correction of feelings of inferiority and inadequacy. The stuttering individual must be given a wise philosophy of life; he must be taught how to make group adjustments. The stutterer must learn to understand his emotional difficulties and then must be placed in an environment in which he can win some success, both in his general adjustment and in his speech. Direct suggestion may be used by pointing out to the stutterer that since he can talk in some situations without difficulty, there is no reason why he cannot in other situations. Indirect suggestion may also be used. Whenever the stutterer

speaks without difficulty, he should be praised for it; and above all, the attitude of the family and of the teacher should be that the stutterer is going to get well. The parents should ignore the child's speech defect. They should not ask him to repeat words on which he stutters, and should not let him feel that they are distressed or worried over his condition.

The use of phonetics or of phonetic vocal exercises is to be avoided. There is no difficulty in the child's speech mechanism. The difficulty is chiefly psychological. Practice in speech, as a whole, and talking to people are to be encouraged, because this is really training the child to meet situations.

One of the most helpful things is the teaching of general relaxation. In this the child lies down and relaxes the whole body—feet and legs, thighs, abdomen, chest, neck, fingers, forearm, upper arm, and, finally, the tongue, jaw, and face. When the child is completely relaxed, he is asked to repeat a sentence, and, later on, to tell a story and to carry on a conversation. When he can do this, he is trained to carry this feeling of relaxation with him as he goes about his daily activities.

Stuttering is one of the earliest signs in the child of an emotional difficulty. It indicates a certain temperamental type that will require careful training. It is for this reason that we feel stuttering to be so important in the field of mental hygiene.

The treatment of stuttering is primarily that of mental hygiene and good common-sense speech work, such as you get in any good class in public speaking. We feel that the field can best be covered by teachers with speech training, who have had also some training in psychiatric social work and who have a right to go into the family, study the family situation and the child, and give the child speech work. In that way, we can best get at the speech difficulties so prevalent in children, which cause so much distress and so much failure.

A NOTE ON CHILD PHANTASY AND IDENTIFICATION

W. LINE

Department of Psychology, Mount Allison University, Sackville, N. B., Canada

THE age at which the child begins to project himself into the lives of others, and to identify himself with parts of the personalities of those whom he loves, is perhaps the most difficult one to investigate and therefore to guide in accordance with scientific findings. The manifold influences that play so dominant a rôle in shaping his character are of that subtle type that defies direct observation. Even yet we are dependent principally on the results of the psychoanalyst for what we know regarding the effective determinants of the ego ideals set up during the period between three and five years of age.

The writer has had under close observation in the home a girl of four years and four months, who is at the present time most actively identifying herself with various elements of the family environment, and whose projection tendencies are serving to give an exceedingly clear picture of her own inner experience. The results would appear to be of value as indicating a typical method for making objective a great deal of the subjective workings of the child mind. It is with this in view that the present note is written. Nothing novel is presented here; the point to be made is merely of general interest to those who are concerned with the first, most important stage of child development.

The child's family consists of the father, the mother, and two daughters. The elder daughter (here under consideration) is at the beginning of the egoistic stage, and her bumptiousness and self-importance are being directed to those little activities in the home that serve to build up habits that will prove of worth in later life. Her interest in family affairs has recently developed an organization of her doll family which goes a long way toward assisting her parents to un-

derstand the progress of her self-control and the conscious and unconscious impulses that are suffering restraint.

Of the whole army of dolls, five stand out in importance. The father is represented by a large Teddy Bear; the mother, by an almost equally large womanly doll. The personalities of these two so obviously represent the child's ideas concerning her parents as to leave no room for doubt. In fact, if we wish to determine the child's attitude toward her parents in respect to any matter whatever, we can invariably do so by creating the necessary situation in the play-family circle. The next member is the neatly dressed girl doll, who passes on the orders of the mother to the baby doll. The first of these is without question the girl's own self, her ideal; and again, to determine the specific attitude of our daughter toward any positive situation, we have only to establish a play environment of a parallel nature. The fifth member is perhaps the most significant of all. He is a naughty boy, and has no objective equivalent in the home circle. Rather he reveals the tendencies that our daughter herself is constantly restraining or controlling. So again a careful watch over the mischief that this renegade is supposed to enjoy unearths a great deal of information regarding the inner impulses of the master of ceremonies in the doll clan. The other members are for the time being entirely discarded, and are left for any childhood friends to mother or destroy or purloin.

A few brief instances may serve to illustrate the obvious nature of this procedure. The naughty boy is constantly being punished by the elder-sister doll, for such misdemeanors as cutting the icing off his mother's cake or for repeating a phrase that seems to express his independence and self-will in a rather questionable manner. The same boy is frequently detected being somewhat rough to the baby doll when the latter is receiving the attention of the father or mother. But no such crimes are ever found in the actions of the elder-sister doll. She is indeed a model of courtesy, displays a deep affection for her baby sister, and helps her parents in the home in every possible way.

Father has many minor faults; he oversleeps, frequently does not answer immediately questions put to him, and is

not always as tidy as mother would wish. But he is respected and loved by his family, and records in his book all that happens during the busy life of the children. The final court of appeal, however, in all matters of discipline is the mother doll; and in character we can find no distinguishing features between her and the ideal-daughter doll.

The ease with which the nursery can here be turned into a laboratory, with none of the artificiality of the clinic, commends the method above exemplified as a valuable supplement to other procedures. It has the advantage of giving the parents an excellent check on their own methods of training and a comprehensive picture of the difficulties experienced by their children.

ITALIAN GIRLS ON AMERICAN SOIL

MARJORIE ROBERTS
The Women's Protective Association, Cleveland

NINETEEN-YEAR-OLD Rosita appealed to the Women's Protective Association because her father allowed her no say as to how she should spend her weekly wage of $14.00, but appropriated the pay envelope himself each Saturday night. Fourteen-year-old Maria was referred to the association by her parents because she wanted to be "American" and stay out all night. Seventeen-year-old Feliciata's father spanked her for slipping out to a corner movie. Eighteen-year-old Anna rebelled at the offer of the man twice her age her parents had selected to be her husband. What has the association to offer in the way of help to these girls, bewildered children of another people, in the confusing and sometimes destructive struggle that they carry on between the ramparts of two civilizations? Can we offer them the same sincerity of sympathy, the same sureness of comprehension, with which we meet the problems of their American sisters? In what, after all, do their problems differ from those of American girls? What difference in point of view and in method of handling their problems is demanded of the social worker who is specializing in the study of adolescent girlhood?

In dealing with an Italian girl, it is essential to realize that one has to do not so much with an individual as with an integral and almost inseparable part of a family group, and that this group is in turn an integral part of a nation—a nation whose love of land has been handed down from the blood-stained hands of Romulus, whose standard for its women is still that of Caesar's wife, whose code of honor is reminiscent of the arena and the imperial thumb, a nation that all our naturalization laws and educational systems fail to Americanize completely. No greater mistake can be made by the beginner in social work, ardent in her convictions and confident of her social standards, than brusquely to

attempt to impose those standards upon minds which century-old habits of thought have made impervious to her suggestions. Deceived as she may easily be by the Italian readiness of hospitality and ease of contact, her efforts in this direction will, nevertheless, prove futile, and further achievement will be hampered. Rather should she bring tolerance and an ever-present realization of the background of these people when she approaches the problems of their daughters. Even then insight will come to her and confidence to them with sluggish steps.

The Italian with whom the social worker generally has to deal is usually either the black-browed, tempestuous Sicilian peasant, the genial, but crafty Neapolitan laborer, the red-haired, dull-witted Calabrian farmer, or the boisterous, self-confident herdsman of the "Camp Basso". In other words, he is generally illiterate, elemental, and unadaptable; he lives in groups made up of immigrants from his own *paese*, or "district", and attempts to live in the "little Italy's" of our big cities the same life he led in his own country. There, after a day spent garnering in fragrant vineyard or olive grove, herding goats on mountain slopes, hauling nets on opalescent seas, or vending melons and lemons through sun-baked, noisy streets, he returns to his cottage or his crowded courtyard flat, and after his dinner of macaroni and fish spends the evening with neighbors and friends, drinking moderately of his wholesome native wines and singing those curious monotonous ballads or doleful sentimental love songs which with him take the place of jazz. On Sunday, after mass, there are general social gatherings in the *piazza* around the principal café, with music from the local band, community dancing, and noisy harangues on popular topics by one or more of the local orators.

The standards set by such an Italian for his daughter are as simple as they are rigid. The outstanding destiny for an Italian girl in Italy is to marry early. She matures earlier than the American girl and is considered an old maid at eighteen, an incurable old maid and family liability at twenty. Education not being considered a necessary preparation for marriage, she receives but little of it (in this matter Italian law is much more lax than ours) and spends her girlhood

closely within the heart of her family. Devolving upon her is most of the housework, the rolling and cutting of spaghetti, the tending of the candles and fresh flowers before the little statue of the family's patron saint, and the care of the younger children, for her mother is usually preparing for or recovering from confinement. While she is under the protection of her family, cosmetics are unknown to her, short skirts and silk stockings disapproved. Public dances are strictly forbidden, and, when permitted to seek amusements outside the home circle, as at birthday parties and weddings, she is always chaperoned by some member of her family. When she is permitted or forced by necessity to earn her living, as occurs only in the larger towns, she works in some lace or embroidery establishment or in some small factory employing women chiefly, performing, casually and unambitiously, the tasks set her, chatting with her neighbors across her loom, or humming happily over her careful stitches. Her work is a daily routine, untroubled by the struggles for advancement or the grinding pace of a speeding-up forewoman.

Prior to her marriage, the Italian girl is not allowed to receive the attentions of any man except her prospective fiancé, who is generally chosen for her by her father from among the sons of his friends, or even from his district relatives, the general strengthening and binding together of the family being a vital consideration in such marriages. Even after the engagement, the betrothed pair are not permitted to go out together or even to see each other alone, though this convention is, perhaps, adhered to more strictly by the leisure class than by families less affluent, whose daughters, forced to join in the general household duties or to enter the business world, have a little more freedom. In the purity of his woman lies the honor and pride of the Italian man. He himself is permitted full liberty; he may even be encouraged to "sow wild oats", and may pride himself on the variety and extent of his sex experiences. But the chastity of his own women is sacred, and he will uphold it with his life. There still exists in certain parts of Italy the custom of having the bride's parents wait outside the door of the nuptial chamber on the night of the wedding for the groom

to give them the assurance of their daughter's virtue, and if he feels any doubt on the subject, he is considered justified in leaving her immediately.

The possible good points of such a system of "girl raising" are obvious. The respect for age and the experience that it represents, the centering of recreation and social life in the home, and above all the serious consideration given marriage and the importance placed on chastity, are all sound bases for the development of wholesome womanhood. Unfortunately, these standards are too often enforced with brutality and injustice and tend to crush the girl's initiative and self-respect, so that she is likely to lack self-reliance and judgment.

Such is the background and such the standards with which the Italian girl comes to America—or, if she be born here, such is the background and such the standards to which her parents still wish her to conform.

Here, as in Italy, the Italian girl is generally the least important member of her family. Her father and brothers, by the very fact of their sex, hold complete authority over the home, while her mother has precedence over her in the respect that the bearing of children always commands among her people. In one family that I know, the nineteen-year-old daughter is the sole support of a hard-drinking, idle parasite of a father, a sick mother, and three shiftless younger brothers, yet she is not allowed to eat at the table and sleeps on a cot in the kitchen, the "males" of course occupying the bedroom. Again I remember walking into the kitchen of one Italian home and finding the twenty-year-old son (a high-school and art-school graduate, by the way) standing firmly planted in the center of the floor directing, with all the authority of a circus-ring master, the scrubbing of the linoleum by his four young sisters, each of them, floor cloth in hand, in a corner from which she was supposed to work toward the center of the room. I have known an Italian to drag his thirteen-year-old daughter by the hair (its being unbobbed was another proof of his authority) before the little statue of the Virgin that stood, flanked by two burning lights, on the parlor mantel, and force her to remain on

her knees before it for three hours, asking forgiveness for having helped herself before him at table to the Sunday chicken.

This submission the Italian father is usually prepared to enforce through corporal punishment; a thorough beating is his way of meeting insubordination, no matter how old his daughter is. In fact, I have known an Italian to take the strap to his married daughter when he felt that her husband was handling her with too American a leniency.

In addition to this subservience, the Italian girl inherits a profound sense of obligation toward her parents, for a feeling of being closely bound to one another in mutual support and protection is an outstanding characteristic of Italian family relationship. However savagely they may quarrel, however bitterly they may complain of one another, the members of the average Italian family have a completeness of confidence and a oneness of interest in their relationship which make for a very splendid solidarity—a solidarity that, even in this country, among the southern Italians and Sicilians, has, when threatened, taken the form of the brutal vendetta.

The Italian girl, as she comes through her school work and her employment into contact with girls of other nationalities and standards, begins to compare her home and her life with theirs, and resents the difference. First of all, she resents her nationality. She meets here a certain intolerance and misunderstanding of her race; its members are called "wops" and "dagoes" and are spoken of as "our criminal class". She begins to feel ashamed of her heritage and incurs the bewildered anger of her parents by refusing to speak Italian even at home and by insisting on adopting American customs and American manners—often much to her detriment, for she is inherently modest and serious and does not make a convincing flapper. I shall never forget the pained indignation of one father when he learned that his daughter, instead of enrolling herself at her place of employment under her own unmistakably Italian name of Augusta Solamoni, had called herself Gussie Solomon.

In explaining later, she said, "With this here black skin

of mine and this big nose, I knew they'd take me for something foreign, and I'd rather any day be took for a 'kike' than a 'wop'."

"Mother of God!" gasped the outraged parent. "And she a Roman!"

The Italian girl who longs for an education, and later a career, comes face to face with a well-nigh insurmountable barrier of opposition. Her parents feel that no education, aside from what she acquires in her mother's kitchen, is necessary. It is difficult to get the Italian father to carry out school laws; he is a frequent offender in evading regulations and falsifying his children's ages in order to secure their working permits. Moreover, he objects strongly to the mixing of sexes in our schools, unable as he is to understand boy-and-girl companionship. As for normal school or college, bitter indeed is the struggle to secure permission and funds for his daughter to enter either. I recently spent three months trying to persuade a prosperous, intelligent Italian business man (who had lived in America thirty years or more) to allow his brilliant seventeen-year-old daughter to attend the state university. He had allowed her to go through high school, much against his convictions, and her desire to continue her studies made him regret having done even that, for he felt that so much school had turned her thoughts from marriage. Moreover, he could not consider letting her go away from home, especially to attend a "school" where young men and young women lived and studied together. His refusal resulted in a quarrel between him and the girl which almost disrupted the family. His wife, torn between husband and daughter, was on the verge of a nervous breakdown, he himself had threatened to leave home, and the girl was preparing to run away, when we were asked to intervene. In the end the daughter was persuaded to give in, and later took a course in nursing in a hospital near her home, where her family could keep close watch of her. The father agreed to this plan on the strength of the plea that nursing was a distinctly "womanly" occupation and would be excellent preparation for future child care.

A far easier task is to secure permission for Italian girls to take up special courses in art or music. It is interesting

to note that the father just quoted unquestioningly paid out large sums for violin lessons for his daughter. The Italians are, of course, above all, lovers of art; the galleries of our opera houses, the Sunday crowds at our museums, are full of them, and the most illiterate Sicilian peasant will greet enthusiastically any sign of artistic talent in his children and encourage its development even in his daughters, in every possible way. It is not difficult to arrange for the training of a gifted Italian girl when it is a financial possibility for the parents.

The Italian girl who works has two serious problems to meet—restriction in the kind of work she is permitted to do and appropriation by her parents of her earnings. Because of her parents' unwillingness to have her live away from home (it is, by the way, a point of honor with an Italian woman to be able to say that she has never spent a night from under her parents' roof till the wedding night) and their strong objection to her associating with men, certain kinds of work are taboo for her. House work is almost entirely out of the question for an unmarried Italian girl who has a family, meaning, as it usually does, that she lives away from her home and in the same house with strange men. Restaurant work and work as store clerk or as office girl are all considered undesirable, entailing as they do contact with men. The most approved places of employment for Italian girls seem to be factories, where they work entirely with other girls under the supervision of forewomen. Italian girls may also be placed successfully in the alteration departments of dressmaking establishments and department stores; they are apt millinery apprentices, and are unexcelled in the artificial flower industry.

Once she is at work, the appropriation of her wages by her parents is the most common problem of the Italian girl. Her pay envelope is usually handed unopened to her father, who in return doles out to her day by day just enough change for her car fare and, if she doesn't take it with her, her meagre lunch. In Italy this method seems perfectly reasonable to the working girl. Her fellow workers all do the same thing, and as her entire life centers in her home and she has few needs beyond those shared with her family, she feels it is

just. But here, where she works side by side with girls who look upon silk stockings, candy, and rouge, rather than the family bread and butter, as the necessities for which they are working, girls whose parents make little or no financial demand on them, the Italian girl begins to realize the possibilities of financial independence and to long for the valuable experience of handling and budgeting her own money. On the other hand, one sometimes finds an Italian father whose pride as the "family provider" will not permit him to touch his daughter's money, even to accept a small sum for board, and this, too, is a disadvantage, as every working girl, no matter of what nationality, should have the experience of facing the problem of having to provide food and shelter for herself.

It is to be noted, however, that when an Italian girl is permitted to go to work, the restrictions placed on her social life are not lessened in the least; rather they are tightened as her family seek to protect her more carefully than ever now that she is coming into contact with the complications of the outside world.

One girl told me that her mother made a note of the exact time at which she returned home every day from work, and that she had to account for every minute of deviation from the regular hour for her arrival. Another girl of twenty was accompanied to and from the factory where she worked every day by her twelve-year-old brother, who, strutting importantly, if a little contemptuously behind her, glared suspiciously at every man they passed and reported faithfully at home every loitering step or sidelong glance of which his sister had been guilty.

Seldom are Italian girls permitted to join clubs or evening classes, such as are offered by settlements and the Y. W. C. A. When they are allowed this privilege, they are invariably escorted to and from the gathering by a parent or older brother, who must be assured that no mingling of the sexes has been allowed.

It is a matter for much delicacy and tremendous tact to make adjustments in the social life of an Italian girl, for one finds oneself face to face with age-old standards and sacred traditions. To encourage an Italian girl to adopt

the American custom of going about unchaperoned, of forming friendships with young men, and of seeking amusements outside her home circle, is sometimes unwise. She herself is by inheritance of a more emotional and less restrained temperament than her American sister, and neither she nor the Italian boy is so likely to keep a clear head or to understand so well as our own young people the wise use of freedom. She will be misunderstood by those of her own nationality and condemned by her own family. She is, moreover, likely to receive little consideration from any Italian boy with whom she associates without supervision. The Italian man has grown to realize vaguely that the liberty granted American women has definite moral limitations, but if one of his own women sets aside even the least of her national conventions, he may assume that she recognizes no restrictions and may be the first to misinterpret and take advantage of her. A charming and quite "Americanized" little Italian girl I knew once made the mistake of letting a young man whose attentions her family approved coax her into granting him a kiss. He at once withdrew his suit, explaining that he now felt he could never trust her.

The custom of leaving to the Italian father the selection of his daughter's husband still prevails in this country, though here the eligibility of the suitor is based largely on the size of his bank account, secondary emphasis being laid on his coming from the same Italian province. Efforts are being made by our juvenile courts and protective associations to prevent child marriages, but this has proved somewhat difficult except in cases where a question of mental or physical unfitness has been involved. Ages are falsified and the marriage solemnized in some other town or state. Perhaps the best method of attacking this problem is to create a feeling against it in your Italian community by getting the priests and other influential members of their own nationality to realize and to proclaim the cruelty and stupidity of such marriages.

In the rare instances in which the Italian girl is a sex delinquent, she is seldom, if ever, forgiven. Even should the family honor be placated by the punishment of the man involved or by his marriage to their daughter, she remains

a marked woman, and her whole family, in having failed to protect her and their honor, share the disgrace. Though court action involving the prosecution of the man and the placement of the girl may satisfy the worker, the parents will still wish to take justice into their own hands. "He is no man", said one father to me, "who gives his honor over, as a plaything, into the juggling hands of lawyers and judges!"

In general, however, unless the home conditions are so undesirable as to warrant action being taken against the parents, every effort should be made to keep the Italian girl in the circle of her family and to persuade her to adapt herself to conditions there. Sometimes it is possible to modify these conditions and to make the family do some "adapting". When, on the advice of her doctor, I once attempted to send an overworked young Italian girl threatened with tuberculosis to the country, I found myself facing such violent opposition from her parents that I seemed lost between the Scylla and Charybdis of either tearing the girl from her family in order to save her life or leaving her there to die. By slow degrees, and through patient effort, however, the parents were made to realize the seriousness of their daughter's condition, to provide her with milk and eggs, to allow her to sleep alone with windows open, to lessen her heavy household tasks, and to take her regularly for reëxamination to her doctor. Thus, though her improvement was much slower than it would have been had she gone to the country, and though each step had to be won by patient and persistent argument and persuasion, the girl's health was eventually built up, and the family solidarity not only maintained, but strengthened.

It is, however, generally difficult to get Italians to adopt our health programs. The public hospitals in Italy were formerly so poorly financed and poorly run that they have come to be regarded by the less intelligent Italian as places to die rather than to recover in. He has also a superstitious feeling against the knife (which is always to him an emblem of death), and it is therefore most difficult to induce him to submit to hospital care here. And because of their insistence upon personal supervision of their daughters, they will

not allow them to be sent away to sanitariums or fresh-air camps. Conditions of general hygiene are more easily dealt with. Windows hermetically sealed against American winters, food cooked in deep baths of unwholesome crude oil (in lieu of the nutritious, but, in America, too expensive olive oil), the unfamiliar bathtub put to strange uses—these are problems in Italian life which education can gradually meet.

America herself, however, is responsible for certain problems that we find in Italian homes. The congestion usually found in our "little Italy's" is one of these. Rents in most of our big cities are exorbitant, and both climate and custom make it impossible for the Italian to eat, sleep, and live in the streets as he does in Naples and other southern Italian towns. We find our Italian families, in some metropolitan centers, at least, packed into such narrow quarters that privacy and even decency are well-nigh impossible. Then, too, the habit of taking in men boarders is learned in this country, and is, among Italians in their crowded quarters, especially dangerous for the young girl.

And what grave complications has not the Eighteenth Amendment brought to Italian girl life! Never in history has the Italian been without his wine. His whole family and social life revolve about it, he considers it essential to his health, and he is in his own country a moderate drinker. With his usual inadaptability, he refuses to accept prohibition. He first takes to manufacturing wine for his own use and then finds that he can sell it at an exorbitant price. With an interest in financial gain combined with few scruples, he feels that the only wrong in law infraction is in being caught, and is not only led into danger himself, but in turn leads his daughter into it. It is frequently she who is called upon to serve the men (mostly Americans) who sneak of an evening into her father's back kitchen, and who are not generally the type of man with whom it is safe for her to come into contact. Frequently her parents deliberately keep out of the way, preferring, in case of a raid, to let their child face a lesser charge in the juvenile court than to face a higher court themselves on a graver charge.

In considering these roughly outlined problems of our

Italian girls, and in aiding them to meet them, let us above all things remember that we will find much to admire, respect, and love in them. The sacredness of their ties, their fine pride and honor, their appreciation of beauty, and their wholesome joyousness are qualities that we cannot help but appreciate and respect, while, in turn, it is for those who have the privilege of working with them to teach them, with patience and understanding, the value of education, the tolerance of individual rights, and, above all, the enjoyment of freedom without lawlessness, of liberty without license.

THE ADOLESCENT "NERVOUS BREAKDOWN"

GEORGE E. GARDNER
McLean Hospital, Waverley, Massachusetts

NO ONE engaged in the practice of medicine has any illusions regarding the value of a diagnosis of "nervous breakdown". Into this ill-defined, but handy pigeonhole can be placed case histories the main symptoms of which may vary from general fatigue to severe post-operative shock and relapse. Hence a "nervous breakdown" is usually but a combination of varying disease factors masquerading as a distinct and definite pathological syndrome, the patient best described as being "physically run down and emotionally wrought up".

The treatment of such cases is varied. The individual sufferer is cured of the specific physical ailment that troubles him; a complete rest and plenty of good food in an environment free from disturbing elements is usually prescribed for him; and as a general rule he recovers sufficiently to take up again his daily routine.

However, the emotional difficulties of these patients ordinarily receive scant attention from the general practitioner who is called in. At best they are vague and elusive factors. The secrecy with which the patient clothes them—his unwillingness to face them himself, much less disclose them to others, for fear of being thought "different" or "queer"—all tend to hide this aspect of the "disease" from the physician, and have led the laity to suspect pure malingering on the part of the patient. Hence the emotional factors persist, potential concomitants of future physical maladjustments. But of equal importance is the fact that these emotional difficulties, in themselves, may be possible harbingers of future mental abnormalities of a more severe nature. As such signs we are concerned with them in this paper. Disturbances at the time of puberty or thereabouts should receive more than passing notice, and it is hoped that a survey of the social, economic,

and educational background and future reactions of adolescents whose illnesses have been diagnosed as "nervous breakdowns" will lead to a clearer understanding of the psychological factors in such cases. Repetition of attacks not only indicates that psychotherapy is needed at the time of the first "break", but should also aid us in formulating and inculcating certain principles of mental health, with an eye to the prevention of future emotional upsets.

On a mental-hygiene questionnaire recently submitted to 512 students in the junior and senior classes of various colleges, the following questions were asked: "Has any physician ever diagnosed a sickness of yours as a 'nervous breakdown'? If so, when? What was the cause of this sickness?" To insure a broad sampling of replies, the questionnaire was submitted in the following types of institutions:

1. A large Mid-Western state, coëducational university.
2. An Eastern university for men only.
3. A large liberal-arts college for men only.
4. A liberal-arts college for women only.
5. A coördinate, non-sectarian college.
6. A Baptist coördinate college in the South.

Of the 512 replies, 280 were from women students and 232 from men. Sixty-one, or slightly less than 12 per cent of all the students, stated that such a diagnosis had at some time been made. Forty-four, or 15.7 per cent, of the women, and 17, or 8.3 per cent, of the men, is the distribution by sex of these sixty-one cases.

Counting six instances in which such a diagnosis had been made on two separate occasions, we have the following distribution of the 59 diagnoses according to the educational status of the 53 cases that were in secondary school or beyond at the time of the breakdown:

High school or preparatory school

Freshman	2
Sophomore	4
Junior	3
Senior	14
Those stating "high school" only	2
Total	25

College

Freshman	12
Sophomore	8
Junior	9
Senior	2
Those stating "college" only	3
Total	34

Six cases occurred "in childhood". Two stated that they had been victims "several times".

It will be seen that the piling up of cases occurs in the senior year in high school and in the freshman year in college. The average age for this group is 16.1+ years, which is significantly low. Situations conducive to maladjustment arising so closely after the awakening of sexual life, combined with the problems of orientation to a distinctly new environment—*i.e.*, that of the college—are probable causes of disturbance at these periods. Equally significant from the causal point of view is the fact that of the 54 cases that gave their age, 22 were accelerated educationally, with an average acceleration of 1.5 years. We immediately suspect a "pushing" process on the part of fond parents, and the additional data on home conditions and overwork in extra-curricula activities would tend to bear out this suspicion. Also, of the 22 accelerated cases, 5 were "only children" and 10 were "only girls" in their respective families.

On the other hand, there were 17 cases of retardation in school, 5 due to illness and 2 to the fact that there was an extra year or more of private preparatory school after graduation from high school. The average retardation was 1.9 years, which, barring the two factors above mentioned, might lead one to suspect these students' scholastic abilities.

The "causes" of the illness as listed by these students can be roughly divided into three main groups:

I. *Overwork*	*Cases*
A. "Overwork" in outside activities	23
B. "Overwork" in studies and fear of flunking	17
C. Lack of recreation and sufficient rest	6

II. *Disease factors*

A specific disease as a concomitant factor was given in 19 cases. These diseases include a variety of maladies such as influenza, appendicitis, measles, neuralgia, heart trouble, and so forth. To the physician regularly engaged in diagnosing and treating college students and to college deans and professors, the prevalence of "eye strain" directly before and during examination time constitutes a veritable semiannual epidemic. Significantly enough, it outnumbers all the other physical "ailments" in our list as the cause of "nervous breakdown", and it generally necessitates withdrawal from college for a semester. Though we can reasonably be suspicious of this "malady" as a refuge in flight, the need for a thorough investigation of the emotional adjustments of these students is seen thereby to be doubly important.

III. *Mental factors*

Twenty-one students listed possible attendant emotional difficulties and maladjustment. Among them were "anxiety", "strange illusions and hallucinations", "over-excitement", "worry", "too lively imagination", "general discontent with everything", "nervous shocks", and so forth. Six had attendant sexual maladjustments ("love affairs", disillusionment, fear, dread); and an equal number were worried about financial matters.

A glance at the so-called "causes" indicates the usual combination group of symptoms that the physician confronts in these adolescent cases, whether they occur within or without college walls; and though the treatment of the individual *as* an *individual,* with his or her own background and reactions in mind, is the only sane approach in such cases, a glance at the home conditions and problems of this selected group reveals certain common experiences which give us in outline a general "type" among adolescent breakdowns.

At the outset it should be noted that there is a marked difference between the male and the female cases. The men for the most part "break" from exhaustion due to overwork in the attempt to make both ends meet financially through outside work, at the same time doing their best to make satisfactory grades in class work. For the most part, they come

from small towns, from large families, and are children whose fathers are employed in clerical, farm, and manual work. The girls, on the other hand, approximate the opposites of these conditions.

Of the 61 cases, 14 were sons and daughters of professional men, the ministry having 6 cases and the rest being divided among the legal, medical, and teaching professions. Fourteen were from "business" homes, and 33 from the clerical, farm, and manual-labor group, 9 from the latter group being male students.

A distribution according to the population of the home town from which these people come is significant only in relation to sex. It was as follows:

	Male	*Female*	*Total*
Small towns (under 10,000 population).....	5	6	11
Secondary cities (under 100,000 population)....	12	18	30
Principal cities (over 100,000 population).....	0	20	20
	17	44	61

The family size and make-up is also significant in the same regard:

	Male	*Female*	*Total*
No brothers or sisters.....	1	6	7
Only one member of opposite sex.....	1	16	17
Families of three or four children.....	5	15	20
Families of five or more children.....	10	7	17
	17	44	61

Eleven of the 44 girls were earning their way through college, 8 earning over 50 per cent of their total expenses. Six of these came from families of 4 or more children. On the other hand, 13 of the 17 males were so employed, 8 of them earning over 75 per cent of their expenses. The five boys from the small towns were earning from two-thirds to all of their expenses, and 7 of the 10 male students from families of 5 or more children were earning a major share of their college expenses. These figures indicate a marked difference in background in the male and female cases.

A further insight into the home conditions of these "nervous" adolescents is obtained from the following data, which are directly concerned with problems arising from diffi-

culties and problems at home. The question was asked: "Are there any situations or persons at home which cause you worry and loss of efficiency while away at college?" There were 47 "yes" answers in this particular group (in itself a high percentage in relation to the number of such answers from the whole 512 cases). The main classifications of situations are as follows:

	Cases
1. Health of parents	11*
2. Financial situation	11
3. Divorce and incompatibility of parents	7
4. Love affairs	5
5. Siblings	4
6. Criticism of behavior, "ideals," etc., by parents	3

* In 4 of these cases, the parent's mental health was the cause of worry.

The potency of the home situation in the lives of these students is also emphasized by further data.

The students were asked to "number (1, 2, 3, 4) in order of severity the situations below that have tended to produce 'the blues', despondency, or other such signs of mental distress". The results were as follows:

*Group ranking**	*Situation*	*Number listing*	*Number listing as "1st"*
1.	The opposite sex	55	16
2.	Fraternity or sorority life	45	8
3.	Religion and God	43	8
4.	Financial	33	11

* The group ranking of each particular situation was determined by obtaining a mean of the rankings given it by the individual student, after the manner of the preferential ballot.

Of the "other situations" that gave rise to such upsets, 9 ranked "home situation" as "1st"; 8, "marks and studies"; 3, "health"; and 2, "future".

A ranking of the content of daydreams in order of frequency brought forth the following distributions from these people:

Group ranking	*Content*	*Number listing*	*Number listing as "1st"* Male	Female	Total
1.	Scholastic success	54	2	13	15
2.	Financial success	58	4	5	9
3.	Social success	52	1	5	6
4.	Professional success	53	4	14	18
5.	Sex	55	4	6	10
6.	Athletic prowess	37	2	0	2

In this specific phase of mental life, sex assumes a much less prominent position with the members of this particular group than with the 512 students reached by the questionnaire.

The reactions of these students to the situations and experiences that are peculiar to the college student are instructive. Foremost among these reactions is the general feeling of inferiority exhibited by the members of this group, coupled with the tendency to remain aloof from their fellow students. The answers to the questions: "In what way do you feel inferior to the other students about you?" and, "In what way do you believe yourself to be 'different' from your fellow students?" show these inferiority feelings in 57 of the 61 cases.

Thirty-nine cases considered themselves "socially inferior", "bad mixers", "more introspective", "moody", and the like. Typical answers on this point are the following:

1. "Sulky mood—because I am not interested in my associates here. I am different from others about me in that I can't socialize with the other students. I am different, too, in that I don't care to have any close friends while in college."
2. "I am very timid. I lack self-confidence. It is hard for me to meet people."
3. "I prefer the company of a book to the company of people."

As the answers of these people indicate, it is not that the other students avoid *them,* but that these students feel themselves not to be one of the group. They sense their *own* shortcomings socially, and in consequence often exhibit an antagonistic attitude toward the cause or source of their feeling of inferiority—*i.e.,* their fellow students. This attitude is much more prevalent in this group than in the group as a whole, the latter generally denying any inferiority whatever and listing "differences" only as assets.

The other inferiority feelings were as follows:

	Cases
Intellectual	8
Physical	6
Financial	4

Such attitudes are further shown in relation to the roommate problem. The students were asked: "As regards your happiness and mental health, has it been your experience that a roommate is a help or a hindrance? In either case, in what

way?'' The replies of all the students showed four favorable answers to one of ''hindrance'', whereas in this particular group the proportion was 31 favorable to 14 unfavorable (only 45 of the 61 cases answering). Some of the answers of the group who found this close association with others detrimental were:

1. ''Not a help—no encouragement—no interests in common. The arrangement on my part is negative adaptation.''
2. ''They usually cannot see my point of view concerning certain things.''
3. ''I hate to be bothered. It's hard enough to put up with yourself at times, let alone another.''

On the other hand, some write in the following vein:

1. ''Good for mental health—gives chance for frank discussions and less chance for daydreams, as problem of sex, etc.''
2. ''Talking things over with her in a sympathetic manner is a great help.''
3. ''We share our worries and talk over our problems. Her help was the only thing that conquered my mood of pessimism.''

To the question, ''To whom do you go for help and sympathy when you have an attack of 'the blues', become despondent, etc., while away at college?'' 21 answered that they go to ''no one''—the percentage in this instance again being significantly higher than that of the whole group of students consulted.

Typical answers are:

1. ''I fight it out alone. I can't confide in any one.''
2. ''I prefer solitude.''
3. ''I have never had any one to whom I could go and fully unburden myself.''
4. ''I am coming or growing to go more and more to my own self, for there is always something there, a cause, about which no one else knows or *can* know.''

Those who *do* seek the aid of another when troubled mentally, go to the following:

1. Parents	11
2. Friend of the opposite sex	10
3. Friend of the same sex	8
4. Roommate	7
5. Church official	2

It is interesting that in only two instances did these people go to any one officially connected with the college (professors,

deans, house mothers, dormitory matrons, college physician and nurses, or the like) and this negligible proportion holds for the entire group of students reached by the questionnaire. Whether this is due to timidity on the part of the students or to the indifference and lack of rapport existent in the college student-teacher relationship we cannot say, but we suspect the latter.

On the other hand, it must be remembered that the college courses themselves contribute in large part to the disorientation of these people, either by arousing new conflicts or by accentuating those already in existence. The following questions were asked of the students: "What college course do you consider to have brought to your mind the harshest personal problems, mental conflicts, etc.? During what college year and semester did you take this course? What personal problems, conflicts, etc., did this course bring forth?" Of the 48 answers to this question, 16 gave psychology; 7, philosophy; 7, sociology, and 5, evolution and the natural sciences. Ten students listed courses the main problem arising from which was the fear of flunking, and 3 criticized the iconoclasm of professors of English courses.

These instances vary from the group as a whole only in the case of the psychology courses. With these 61 cases, 16, or a little over one-fourth, listed psychology, whereas of all the 512 students questioned, 86, or a little less than one-sixth, gave psychology as a "problem" course. Some of the problems brought forth are stated as follows:

1. "Mainly sex problems—especially sublimations and perversions."
2. "The question of some dreams I used to have repeatedly."
3. "The problem of myself—what is the cause of my emotional upsets, etc."

As the effect on these people is essentially the same as that given by the other students who found psychology troublesome, it may be that the professor in these courses is losing an opportunity to help in adjusting conflicts, and is, instead, adding more. The writer feels himself equally guilty in this matter, and though we are rather dubious as to the desirability of sugar-coated pellets of collegiate instruction in controversial courses—or in any course in which subjective reference of abnormal processes is possible—perhaps we can

foster a better rapport with our students in the matter of the mental conflicts that may ensue therefrom. At least, a group of lectures on the simplest principles of mental hygiene would probably be beneficial.[1]

We have tried thus far to outline the salient characteristics of the adolescent nervous breakdown in relation to home environment and special mental problems. We feel that these cases should have the special attention of the practicing physician, as he is usually in a position to aid these people at the first indication of mental distress, and the failure of the individual to become adequately adjusted at this time may result in more serious abnormalities.

An indication of this is seen in the fact that 10, or one-sixth, of these breakdown cases later seriously contemplated or actually attempted suicide. And one-fifth of all those in the whole group of 512 students who had had such impulses are found in this particular group, which comprises only 12 per cent of the total number.

In conclusion, it may be of interest to outline two of these cases:

Case 200.—Daughter of a lawyer living in a city of 100,000 population. She intends to become a missionary. Does not earn any of her college expenses. As a senior in high school (aged seventeen) she suffered a nervous breakdown due to "mother's ill health; mental worry and eye strain in trying to finish high school and 'carry on' at home. I was out of school a year because of it." Her reactions to college life and students are as follows: "Disappointed in college because it seemed to question and destroy all of the things which had been fundamental in my life." As for her general predominant mood: "Inferiority complex. I guess; nervousness and tendency to physical weakness." She "feels inferior to her fellow students socially", though she is "trying to overcome this and needs help". In her course work she also "feels inferior mentally to the other members of the class". Situations that cause despondency are, in the order of their severity: (1) the opposite sex, (2) financial need, (3) religion and God, (4) "self-introspection and desire to be popular". Her "mother's health, loss of father, and financial need" are home conditions causing worry. The daydream contents in order of frequency are: (1) sex, (2) social success, (3) financial success, (4) scholastic success, (5) professional success. She has been both "helped and hindered by roommates" she has had. She considers herself to be "different" from the other students in that "I am not so good looking, not so quick to learn, and cannot do anything

[1] For a further discussion of this subject, see *The Psychology Professor and Student Mental Hygiene*, by George E. Gardner. MENTAL HYGIENE, Vol. 12, pp. 789–93, October, 1928.

in athletics". During her sophomore year in college she seriously contemplated suicide because of "financial responsibility, grief, and general despondency".

Case 107.—Daughter of teacher from a city of 120,000 population. She intends to become a teacher. As a senior in high school (aged seventeen) she suffered a nervous breakdown due to "general run-down health, too steady work, and not enough healthful recreation or outdoor life. Tonsils, etc." Psychology in college "wrecked the ideals and beliefs that I had had, and the professor did not ease me over the transitional stage". Causes of despondency in her case are: (1) "I can't define it—a state of health—often things discussed in 'bull fests' at the sorority house"; (2) the opposite sex; (3) sorority life; (4) financial need. She is further worried about her mother's health and unhappiness. Daydream contents in order of frequency are: (1) sex, (2) social success, (3) scholastic success, (4) financial success. Roommates are a hindrance to happiness in that "they bother you by boring details of their experiences, affairs, or family when you are trying to accomplish something". She as seriously contemplated suicide "several times" because of "despondency—a feeling of not actually gaining or doing anything worth while". She confides in no one when despondent, but "fights it out alone".

Students of this general make-up probably do not differ radically in background and reactions from those outside the college environment who have encountered emotional difficulties at adolescence. Nor have we any figures to show probable future upsets. Yet although no causal relationships can be shown, we can see that we have before us a group of individuals who have been maladjusted from an early age, and whatever psychotherapy is advisable or possible to insure their future happiness and efficiency could probably best be attempted by the family physician.

Again, the fact that 8 had a recurrence of emotional difficulties and 10 others had seriously contemplated suicide, coupled with the none too favorable social reaction on the part of the group as a whole, indicates that the college has within the student body a group who seem disposed to emotional upsets and difficulties. In this respect it might be well for the college physician to broaden the scope of the compulsory freshman course in physical hygiene to include a discussion of the known laws of mental health.

THE ORGANIZATION OF CHILD GUIDANCE AND DEVELOPMENTAL SUPERVISION *

ARNOLD GESELL, M.D.

Director, Yale Psycho-Clinic, New Haven, Connecticut

CHILD guidance is a new term that has gained wide currency. If it is not used too promiscuously or too pedantically, it serves a useful purpose. Already it has unlocked new efforts in school, court, clinic, and home, and has developed a new regard for the personality factors that underlie child problems.

The general concept of child guidance arose out of the clinic. It represents the physician's way of looking at life problems. Guidance, here, does not mean education or admonition in a narrow sense. Rather, it means a case study, a diagnosis, and a considered effort to appraise and regulate all those factors that need adjustment in the individual and in his associates. Although the more difficult and technical forms of child guidance require medical oversight, the general method and spirit of approach may be imitated by intelligent teachers and parents. In fact, much child guidance actually resolves itself into parent guidance and consists in bringing the parent to an improved relation with daughter or son.

It is idle to attempt to define so plastic a term as child guidance. Suffice it to say that in some degree, more or less serious, the mental health of the child is involved. He may be bright, average, dull, or deficient, but from the standpoint of mind or conduct, he is not functioning or developing up to his possible optimum. Guidance in practice becomes a constructive effort to improve his mental health. Many share in the effort—physician, nurse, visiting teacher, school principal, policeman, big brother, uncle, grandmother. But always there is implied some kind of diagnosis, some analysis of the problem, and a program of ways and ends.

* Summary of a paper read at the New Orleans Child Conference, October 26, 1928.

Child-guidance technique has been most highly developed in work with juvenile delinquents. The child-guidance clinics conducted as demonstrations under the auspices of The National Committee for Mental Hygiene have shown how the social, educational, and medical resources of a community may be mobilized to do preventive work in the field of delinquency and conduct disorder.

Preventive mental hygiene must begin early to accomplish maximum results. It is becoming increasingly apparent that in the protection of mental welfare, as well as of physical welfare, society must concentrate its basic effort upon infancy and early childhood.

The whole pre-school period, from birth to second dentition (at six years), is comparatively a very critical epoch in the development of the individual. Death, disease, and accident take their heaviest toll during these early years. Three-fourths of the deaf, three-fourths of the speech defective, virtually all of the mentally deficient, one-third of the crippled, and a large proportion of the blind come by their defects in the pre-school years. Even accidents like scalding, falls, and traffic casualties fall with peculiarly heavy weight upon the young child. The automobile each week takes its tragic toll. Who are its preferred victims? Children. And who among the children are preferred? The very young. One-half of all the juvenile-traffic deaths are of children three, four, five, six, and seven years old.

In the aggregate these figures have much significance for the relatively normal as well as for the handicapped child. They mean that the hazards and the opportunities of development alike are great during this swift-growing period of the life cycle. Some part, at least, of the foundation of mental health must be laid in the pre-school period of growth.

But mental growth continues during the whole period of immaturity. Indeed in fortunately gifted and well-minded individuals it may continue far into adult years and even to the brink of old age. The foundational importance of the pre-school period rests upon the priority of this period. No one can deny the plasticity and the potencies of later childhood, of youth, and of adulthood. A complete view of the whole domain of child guidance and of developmental hygiene will recognize

the continuity of all the ages of man, and will emphasize the interrelations of the entire sequence of life periods.

Growth is a unifying concept which expresses the internal unity of the entire life span. All growth is automatically self-conditioning. Past growth modifies present growth and both project themselves into the future.

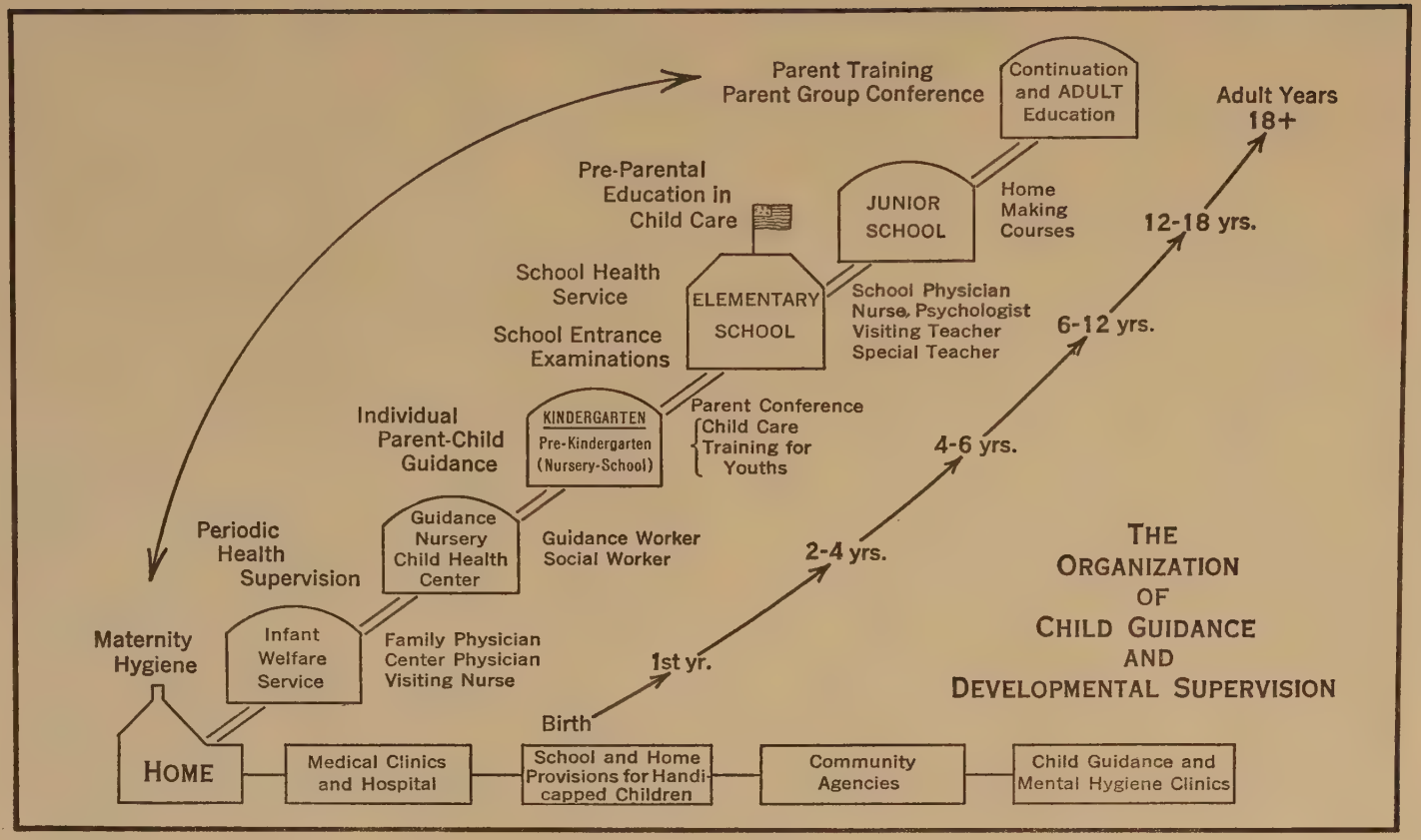
The broad problem of the organization of child guidance and of developmental supervision may, therefore, be envisaged in terms of the sequence of life periods that make up the cycle of mental growth. In the following brief and very sketchy summary, no attempt will be made to define the administrative details of organization. The administrative scheme will vary for different communities and it can never attain completion. It should so vary because the soundest child-guidance policies must take shape in terms of the peculiar resources of each community.

The accompanying chart (page 783) outlines diagrammatically the life periods in a comprehensive organization of child guidance and developmental supervision. The chart is intended to show schematically the relations of such service to existing resources in the field of child hygiene and education.

1. Infancy (*birth to two years*).—For this period society is laying bed rock. The foundation is not yet solid, but it is being laid. Private medical practice, public-health measures, and governmental legislation alike are increasingly directed toward preserving the lives of the newborn child and his mother.

The first infant-welfare consultation center was established in Paris a generation ago. It has flourished like the mustard seed and has been adopted the world over. The attitude and the technique of pediatrist and nurse in the supervision of the development of the infant constitute in many ways the most significant advance that has been made in modern preventive medicine.

The protection of infant life leads to the augmentation of life. The new concern for the safety of birth and babyhood does not stop with measures directed against disease and death. The supervision of the infant's nutrition inevitably broadens into a solicitude for his total economy. The infant's


Parent Training
Parent Group Conference
Continuation and ADULT Education
Adult Years 18+
Pre-Parental Education in Child Care
JUNIOR SCHOOL
Home Making Courses
12-18 yrs.
School Health Service
School Entrance Examinations
ELEMENTARY SCHOOL
School Physician
Nurse, Psychologist
Visiting Teacher
Special Teacher
6-12 yrs.
Individual Parent-Child Guidance
KINDERGARTEN
Pre-Kindergarten
(Nursery-School)
Parent Conference
Child Care
Training for Youths
4-6 yrs.
Periodic Health Supervision
Guidance Nursery Child Health Center
Guidance Worker
Social Worker
2-4 yrs.
THE ORGANIZATION OF CHILD GUIDANCE AND DEVELOPMENTAL SUPERVISION
Maternity Hygiene
Infant Welfare Service
Family Physician
Center Physician
Visiting Nurse
1st yr.
Birth
HOME
Medical Clinics and Hospital
School and Home Provisions for Handicapped Children
Community Agencies
Child Guidance and Mental Hygiene Clinics

well-being hangs not alone on vitamins and calories, but on his mode of living, on his habits, on the behavior of his parents. Accordingly, the administration of prenatal hygiene is bound to bring into its scope the psychology of the parent-child relationship. The problem of nutrition is so fundamental that by implication and often by actual exigencies it includes the psychological and the functional aspects of development. Thus the weighing and measuring of the infant become the germ of a broader type of developmental supervision. The family physician and the practicing pediatrician are compelled to reckon with numerous problems that lie in the field of mental hygiene and child guidance.

2. The pre-kindergarten period (two to four years).—Until recently this transitional period received scant social attention. Now it is fully recognized in theory and increasingly in practice that the medical supervision of the infant by the welfare station and by the family physician must not be allowed to lapse. If the infant is examined weekly and monthly before his first birthday, surely there should be a series of periodic health examinations annually and semi-annually in the years from one to six. But the toddler and later runabout is a young personality who is claiming educational oversight. He is a habit-forming individual subject to the laws of mental hygiene. The child-health center, if it is conducted on a true consultation basis, must constantly raise issues that relate to mental well-being. These early child-guidance problems cannot be escaped nor should they be transplanted to other areas of the social organization. Here is their natural setting.

At this early age child guidance is parent guidance. The nursery school has been invented as a device for furnishing new educational opportunity to normal children and to their parents. Whether the nursery school should develop into a supplementary pre-kindergarten as a tax-supported annex of our public-school system is a question of great complexity that will not be quickly solved. Meanwhile the nursery school is rendering valuable service in defining the interdependent problems of pre-school and parental education.

It is possible to organize and to conduct nursery-school

work on a guidance basis. A guidance nursery functions like a dispensary unit, reaches a larger clientele, and focuses directly upon the guidance of the individual parent in relation to the individual child. It combines the technique of dispensary, consultation center, and school. The flexible individualized methods of the guidance nursery under clinical auspices are readily adapted to problem and handicapped children, as well as to normal children.[1]

3. The kindergarten period (*four to six years*).—The American kindergarten is in danger of crystallizing into just another schoolroom, when to meet the new demands it must develop a versatile, multiple technique which will bring it into more effective contact with a wider range of childhood. Instead of becoming fixed as a schoolroom, the kindergarten may evolve into an educational service instrument, a kind of dispensary that will be staffed to do a certain amount of routine, but that will be organized and geared to render special educational guidance to parents and also to children of pre-kindergarten age.

The position of the kindergarten in the educational scheme is unique and strategic. The kindergarten is the recruiting station of the public-school system. As such, there is every reason to hope that it will establish increasing contact with children of pre-kindergarten age and with their parents. By

[1] We have put these methods to a test at the Yale Psycho-Clinic in our work with children of pre-school age. Our guidance nursery, in charge of a guidance worker, is used as an adjunct to the clinic for the observation and adjustment of children who present behavior problems. Children come individually or in small groups by appointment. An observation alcove is part of the nursery equipment. The alcove, with a one-way-vision screen, permits the parent, unobserved, to follow with some detachment the child's readjustment under the auspices of the guidance nursery. This observation arrangement has proved serviceable in the practical carrying-out of child-parent-guidance work. (Details are described in the writer's *Infancy and Human Growth*. New York: The Macmillan Company, 1928.)

The techniques for infant-guidance work must be developed in close association with the medical supervision of the mother and child. Problems in this field have been studied at the Yale Psycho-Clinic in connection with periodic developmental examinations of infants, and an infant-parent-guidance service has been inaugurated at a small suburban infant-welfare center. The work is in charge of a pediatrist in coöperation with a child psychologist. This unifying arrangement incorporates the developmental supervision with the regular health supervision of the infant-welfare center.

a judicious penetration into the region of the lower age levels, an articulation with infant-welfare activities can be evolved.

4. The elementary-school period (six to twelve years).—No artificial distinctions should be made between child guidance and education. But education in the traditional sense is still in danger of being identified with curriculum rather than with the life career of individual children. Academic education is directed toward intellect rather than personality. The concepts of child guidance and of mental hygiene shift the emphasis to personality and stress the importance of the parent-teacher relationship as being dynamically like the parent-child relationship. The diffusion of the concepts of mental hygiene and child guidance among the large army of elementary-school teachers will have incalculable benefits in the promotion of normal psychological development. Normal schools are potential centers for such diffusion.

5. Adolescence (twelve to eighteen years).—At adolescence the cycle of life begins to turn on itself. The home-making courses of the junior high schools are beginning to take cognizance of this fact. The infant was a prospective kindergarten pupil. He has now become a youth and is ready for anticipatory contacts with the problems of child training. This youth, whether boy or girl, is ready to assimilate in later adolescence much concerning the psychology of child development. Broadly conceived, there is nothing more fundamentally important for the advancement of the objectives of child guidance and mental hyigene than a wide dissemination of provisions for pre-parental education.

6. Adult years.—It is significant that the great national movement in behalf of the pre-school child has been paralleled by another significant social movement—namely, that of adult education. The pre-school movement and the parental-education movement are coördinate because fundamentally they are inseparable. The whole movement of parent education happily makes the assumption that adults can be educated. In much of our social planning it is easy to focus too exclusively upon the child as if he alone were plastic. The child, after all, is somewhat of an abstraction. He can exist only in relation to adults, and because of the funda-

mental character of this relationship, the whole technique of child guidance must swing its emphasis to the adult and to the adolescent.

The sketchiness of this survey has enabled us to envisage the successive life periods in close juxtaposition. It becomes apparent that the broader problems of the organization of child guidance can be solved only on a wide community basis. The medical, social, and educational aspects of the task cannot be separated, nor should special age periods be partitioned from one another. A comprehensive scheme of developmental supervision pictures itself ideally as a working unit, with the promotion of optimum growth as the inclusive aim.

UNDERGRADUATE ATTITUDES TOWARD MARRIAGE AND CHILDREN

STUART A. RICE
University of Pennsylvania

IN 1925 Professor Malcolm M. Willey and the present writer made some inquiries among their undergraduate students of sociology at Dartmouth College designed to throw light on mores and attitudes with respect to family size.[1] Our data seemed to show that while the majority of the men in our classes looked forward to a marriage that would include children, the number of children desired was insufficient, if realized, to provide for the perpetuation of the group. We felt it reasonable to assume, since control over the birth rate has increasingly become voluntary, that these attitudes would be reflected in the size of the actual future families of these young men.

The results of this earlier inquiry seemed sufficiently interesting to warrant securing comparable data from another institution. These have been procured from several undergraduate classes in elementary sociology at the University of Pennsylvania. They have the added interest of representing both sexes. Moreover, the students of this metropolitan university have on the whole a different social background from those of the small New England college.

Anonymous and voluntary answers were given to the following questions:

1. State your university class, your sex, and age.
2. Do you ever have daydreams or fantasies of marriage?
3. If so (affirmative answer to Question 2), do you ever picture yourself in these fantasies as having children?
4. If so (affirmative answer to Question 3), how many?
5. Remarks.

[1] See "College Men and the Birth Rate", in *The Journal of Heredity*, Vol. 17, pp. 11–12, January, 1926. Reprinted in MENTAL HYGIENE, Vol. 10, pp. 888–90, October, 1926, and reprinted in part in *The Science of Social Relations*, by Hornell Hart (New York: Henry Holt and Company, 1927).

These questions in order were read to each of a number of classroom groups by the present writer, and written answers were given immediately by each student. The attempt was made by a prior verbal appeal to secure replies that were sincere and unreflective as to Questions 2, 3, and 4. Important variable conditions as among the several groups were, first, size and, second, preceding or concurrent discussions in the classroom of such subjects as population, differential birth rates, and eugenics. A class in the Wharton School of Finance and Commerce and one in the College of Liberal Arts, each composed of men exclusively, were given the questionnaire during a period of the course devoted to a discussion of the topics just mentioned. This was true likewise of a larger group, mixed, but composed primarily of women, in the School of Education. In the latter, the questionnaire was repeated in a second-semester course several weeks after the discussion of the problems mentioned had been passed by. In all classes a majority of the subjects were sophomores, with a scattering of juniors and a still smaller number of seniors. A few freshmen were enrolled in the School-of-Education courses.

In the following table (page 790) the data have been summarized in columns, A to G. The Dartmouth data for 1925 are included for comparison. The Roman numerals in the first unlettered column at the left refer to the first or second semester. The men in the two School-of-Education classes have been placed together because of their limited number.

In calculating the average number of children desired (Column D), only those who gave a definite number or numbers were included. When a range was indicated, the mid-point was taken in arriving at the average. For example, all who expressed a wish for "two or three" children were tabulated as desiring 2½ each. The averages appearing in this column seem to be the most significant as indicators of prospective family size. However, averages based upon the total numbers of students appear in Column E.[1] The figures in Columns D and E may be compared with various estimates of

[1] Those who expressed a desire for an indefinite number of children were again omitted from the calculation.

the number of births per family required to preserve a constant population in a given group. Thus L. I. Dublin, quoted in our earlier article, calculated that, on the average, 3.1 children per married couple having children were needed to preserve a constant population.[1] Another means of summarizing the individual preferences has been employed in Columns F and G. These show, respectively, the percentages of the entire number desiring children who wish to have two or less and three or less. At the University of Pennsylvania, more than three-quarters of the women and more than four-fifths of the men who *wanted* children desired a number less than sufficient to preserve their respective groups at a constant number. The corresponding ratios for the Dartmouth men were intermediate between these two.

	A	B	C	D	E	F	G
Institution and class	*Number answering*	*Having day-dreams of marriage*	*Also having day-dreams of children*	*Average number of children in fantasy*	*Average number of children wanted, based on Column A*	*Percentage in Column C wanting two children or less*	*Percentage in Column C wanting three children or less*
Dartmouth College							
Men (1925).....	90	83	79	2.7	2.3	50.7	80.9
University of Pennsylvania (1928–29)							
All women.....	130	113	99	2.7	2.0	45.2	75.8
All men.....	83	65	61	2.4	1.7	52.6	83.1
School of Education							
Women (I).....	62	55	49	2.8	2.2	43.7	77.1
School of Education							
Women (II).....	68	58	50	2.6	1.9	46.8	74.5
School of Education							
Men (I and II)..	27	17	16	2.7	1.9	31.2	68.7
Wharton School							
Men (I).....	32	30	28	2.2	1.9	70.4	85.2
College							
Men (I).....	24	18	17	2.3	1.6	41.2	88.2

Under the heading of "remarks", a variety of attitudes were disclosed. The number of both sexes who resisted the

[1] See the *Journal of the American Statistics Association*, March, 1925. We also quoted S. J. Holmes in *The Journal of Heredity*, October, 1924: "It is, therefore, a matter of doubt if, with our present death rate, an average of 3.5 children would suffice to reproduce the general class of fairly well educated people who supply our college students."

suggestions of marriage and children, or who were emphatic in their negative responses, was small. Negative answers to Questions 2 and 3 were sometimes underscored or followed by exclamation points, and by one or two the questions were characterized as "ridiculous". The opposition was sometimes more rational, hinging around the desire for a career.

A young woman, aged twenty, a sophomore in the School of Education, stated: "I hope to have a career and in view of this I do not fit children into the general scheme." Another, nineteen, does not intend to marry because of a hoped for career as a chemist. A young man of twenty-two, a junior in the School of Education, seems to have been motivated in somewhat the same way when he remarked: "Little time for such reflections." But another young man in the same class represents in his remarks a much more prevalent point of view: "I feel that joy in my children, especially if at least one is a boy, will be the greatest feature of my later life." A young woman of the same age and university standing and in the same class says: "It is every girl's ambition to be married. Marriage is the culmination of the heart's desire."

An interesting characteristic of a large number of the replies is the definiteness of the preference. The number of the children desired is frequently accompanied by a statement as to their sex. The large number who desire two children frequently state a preference for a boy and a girl. But a young woman who desires six children asks for three girls and three boys. Another wants two of each. Occasionally this even balance is varied, as by a young woman who wants two boys and one girl. A young man in the School of Education wants six children, all to be boys. A young woman wants twins of unstated sex and has even decided upon their names.

Another type of remark that recurs frequently lends support to the theory of relationship between standards of living and the birth rate. The number of children wanted is frequently made to depend upon the capacity for maintaining subjective living standards. The following quotations indicate this attitude:

College, male, aged nineteen: "I should like to have two children, to be a boy and girl. I feel that I should not be married until I could adequately support a wife nor should I have any children until I could be able to support them in some luxury."

A young woman: "Number depends on ability to support."

A young woman: "Four to six children provided my future husband and I are economically, physically, and morally capable."

A young woman: "Four if we are sufficiently wealthy."

A young woman: "I come from a family of more than four, and I realize the value and joy of brothers and sisters. I would not like to have just one child—nor do I think it fair to have more than the income would educate."

A young man of twenty-one: "The size of family depends on my income."

A young woman of nineteen: "I often picture myself as having three children, but if I were well off financially, I should want more."

A young woman of eighteen: "As many as I can afford to rear decently. If I cannot raise children in the manner I wish, I shall not have any."

A young woman of twenty: "As many as I find I can comfortably clothe and educate. The number, I should say, is three or four, certainly more than one."

Evidences of the "modernistic" attitudes with which the younger generation of to-day is sometimes said to be imbued occur occasionally, although rarely. A young woman who daydreams of marriage and of two or three children remarks: "I should prefer having children without marriage if I were in a financial position enabling me to go against public opinion." A young man in the School of Education asserts: "I can't conceive of myself marrying under the present marriage system."

The foregoing are the most conspicuous expressions of trend of attitude, although other matters of interest are present. In the first-semester questionnaire in the School of Education, for example, a peculiar type of symbolism appeared on five papers submitted by women, the standard perforations of notebook paper being enlarged by pen or pencil. There was no evidence of design or imitation, but nothing similar appeared on the papers in any other group of subjects. Again widespread interest in eugenic and birth-

control propaganda was evidenced in the column for remarks. This may be regarded as in part the result of rational points of view developed during classroom discussions.

The results of the study are undoubtedly calculated to induce pessimism so far as prospects for the birth rate are concerned. On the other hand, they indicate a general, intelligent, and wholesome anticipatory interest in their prospective families on the part of the subjects.

SUGGESTIONS AS TO THE DETECTION AND TREATMENT OF PERSONALITY DIFFICULTIES IN COLLEGE STUDENTS

G. H. ESTABROOKS, PH.D.
Associate Professor of Psychology, Colgate Univesity

THE following article was written from the point of view of an institution that has no regular psychiatrist and must rely largely on its own devices. As such it may be of interest to others in a similar situation.

The work of the personnel department at Colgate covers a wide variety of activities. One phase, however, may be of special interest to the readers of MENTAL HYGIENE. I pass it on for what it is worth. This phase consists in the early detection and remedial treatment of the incipient nervous breakdown. With the opening of the college in September, this becomes one of the first and most important functions of the department, for early recognition means the avoidance of trouble.

The first step toward this early detection — as well as toward other ends—consists of giving various tests to the freshmen. This battery includes the intelligence test for college freshmen as prepared by the American Council on Education, the vocational-interest blank of Professor E. K. Strong, and the Colgate tests for the detection of psychoneurotic traits and for introversion-extroversion.

Experience has shown us that trouble is very liable to center in two groups as revealed by these tests—first, in the lower tenth, roughly, of the intelligence scores and, second, in the higher tenth of the psychoneurotic scores. Consequently, the next step is to call in these groups, of about thirty each, at the earliest possible moment.

Students in the first group are seen in the week after the opening of college. The procedure here differs from that employed at most institutions in that no concealment whatso-

ever is made of the reason for the interview. The student is frankly warned that his score is low and that he may have difficulty with his college work. He is, however, assured that he has ample ability to do his work if he will but apply himself. It is then pointed out to him that success in life bears only a low correlation to mental ability, and that his low score on the test, even if it does mean something, has no more significance in relation to his after success than his ability to run the hundred in ten flat or to sing *The Star-Spangled Banner* in a concert voice. This is, of course, a slight exaggeration. At the same time he must be prepared to work and work hard. Therefore, he is warned not to load up with extra-curricular activities until after the first semester at least.

These conferences have a twofold purpose. In the first place, they serve to warn the student that he is up against a serious task. We feel that if this is done tactfully and in such a way as to insure no loss of self-respect, nothing but good can result. We do not overstress the test, but we have found very significant correlations between test results and college success. We do our best to warn the student against the approaching danger, while doing everything possible to avoid establishing any inferiority complex. Secondly, the interview affords an excellent opportunity for sizing up the freshman. It is reasonably easy to judge whether a student is nervously unstable simply by talking to him and getting his ideas on various topics, such as religion.

The second group interviewed consists of the upper tenth in the psychoneurotic tests. These men are also summoned to the office the first or second week of the term. The reason given is generally a fictitious one, such as a vocational conference or a request for further information about pre-college credits. These interviews are purely for the purpose of looking the student over from the point of view of nervous stability. Any member of the two groups already mentioned who impresses the interviewer as being likely material for a nervous breakdown is noted for further supervision. This part of the program is carried out by the writer, who also instructs in abnormal psychology and so has some theoretical basis on which to judge.

The third group of interviews takes in every member in the freshman class. The ostensible reason for these is vocational and educational guidance, but a very important, if minor, consideration is to look over the student from a mental-hygiene standpoint. These interviews, however, take time and cannot be completed before Christmas. Hence it is felt necessary to do everything possible toward locating the problem cases without waiting to see every student individually. The two first groups mentioned will yield about one-half the suspects. The rest must be dug out by other and more devious methods. The following hints, if carried out, will leave very few of these remaining suspicious cases unnoticed.

First, it is always a good hunch to look up the instructors in rhetoric and debating. Any boy who stammers or who is excessively nervous on his feet is a possible case and should be called in for an interview.

Second, freshman courses in religion and ethics are liable to bring neurotic traits to the front. At Colgate we have an orientation course in religion and ethics which enrolls almost half the freshman class. The student who is suffering from conflicts has an excellent opportunity of airing these in such a course and so bringing himself to the notice of the instructor.

Third, at faculty meetings all instructors of freshmen and sophomores are urged to report any "queer" students to the personnel department. In this way a number of cases have been brought to our notice by instructors whose plea is: "I do wish you'd take a look at So-and-so. He's a funny sort of chap and I can't seem to understand him."

Fourth, it is a very excellent idea to take a certain number of the freshman class into your confidence. Thus, about one in every ten men will strike you as being a man who is very well balanced and sane. Ask him, quite frankly, if he won't keep an eye open. Make it quite clear that it is not a matter of discipline or snooping. All you want is to know about the fellow who seems excessively homesick or unhappy, or who doesn't seem to fit in, and above all any one who begins to complain of lack of sleep, to skip meals, and to act

"queer". This will generally result in bringing a number of cases to the attention of the department.

A fifth source of information is the health department of the university and the various medical men in town. The university doctor in a small institution is generally a pretty busy individual who has not had special training in psychiatry. Nevertheless, he is invaluable in detecting cases and locating organic causes. Theoretically, he should be a psychiatrist. Actually, it is a case of "try and get one". The town medical men can also be of great assistance. There are many cases that never come near the college physician. For instance, a village practitioner warned me about a budding case of syphilo-phobia this last semester.

Finally, it is astonishing how many cases will just drift into the office of their own accord. They feel that something is wrong, they realize that they are not getting along as they should, they hear of the personnel department, and the first thing you know they arrive on some fake errand, which is merely an excuse to give them a chance to talk over their woes.

Having detected these problem cases, what next is to be done? We are an institution without a psychiatrist on our staff, but we are also very close to a couple of excellent hospitals and medical schools. They serve as a basis of reassurance, so to speak. If we ever really need high-grade help, we can get it. Otherwise we have to blunder along with our own wits as best we may, which is just the position of nine-tenths of our colleges at the present time.

The first step, we feel, is that of distinguishing the acute cases from those that are of a less pressing nature. The man who is suffering from a severe attack of "homesickness" or who has only a personality difficulty can be handled by sympathetic understanding. Perhaps we should say that he can be handled reasonably well. On the other hand, a man with a hand-washing mania or one who tries to commit suicide is quite another problem. The average amateur—and that term includes psychology professors who have not their medical degrees—is hopelessly at a loss when confronted with a good case of, say, claustrophobia or a budding paranoiac. Experience, I think, rapidly shows the type of

case that needs expert treatment, and this must then be called in as soon as possible.

The average psychiatrist will disagree violently when I say that such cases form a definite minority. He is right—and so am I. We should have a high-grade psychiatrist on every problem case; only, in the first place, there aren't enough Healy's and Bronner's to go around, as has been pointed out before. Secondly, most institutions cannot afford such luxuries just at present. So we get on with what we have and pray for a better day to come.

The first move, then, is to get such men as need it in touch with an expert psychiatrist. These, with us, form a small minority. Far more important in a small college is the problem of dealing with the individual who is a potential nervous breakdown. This, in our case, consists in rapidly locating him, as already described. The next move is a process of continual check-up. We have about thirty of these problem cases on file. They are mostly from the freshmen class, but there are plenty of hang-overs from former freshman classes who still require careful watching. We make a point of seeing them on an average of once every two weeks, oftener in some cases.

This does not call for a formal interview—merely a word as they are encountered on the campus or at the various college functions. Everything possible is done to have them retain their self-respect and good feeling toward the institution. Encouragement is the keynote, with an attempt to gain their confidence, so that they will listen to straight, plain talk. Above all things the department must be a step ahead of them at all crises. The monthly examinations are always danger points, since an examination is a definite show down—a process that no neurotic individual takes to very kindly. Consequently, these suspects who are low in scholarship are always seen on various pretexts just before examination time. They are then assured that the college has the greatest faith in them, that the faculty realize the handicap under which they are struggling—sometimes very real, by the way—and after all, what's a little thing like an F between friends? Better men than they have accumulated several; they will

probably go into business, and intelligence doesn't seem to bear any relation to business success anyhow.

This attitude, coming from the dean's office, seems to do away with a good deal of trouble. We even go so far as to hold up deficiencies that should normally be reported to their parents or to allow unlimited cuts for exceptional men in certain courses. This is not a regular policy, but we are very fortunate in having an administration that will literally "go the limit" if it seems necessary in order to fit the school to the student.

The result of this procedure for dealing with our problem cases is very interesting. This year we have not as yet dropped a student for nervous trouble. There are several cases that I am morally certain would have crashed if it had not been for the sympathetic understanding of the personnel department and the leniency of the dean's office.

Most important, however, is the constructive work that can take place. A number of these men, when they get to their sophomore year, have a fair insight into their own condition and a genuine desire to help themselves. They will then come into the personnel department of their own free will, sit down, and discuss their shortcomings. Far more important, they will listen to pretty severe criticism and react in a very frank and open manner. They are always urged to read along the line of their own case and to develop as much insight into their own condition as is possible. By this means we hope to bring about a reasonable adjustment.

In closing, we would again stress the fact that such work as that herein described should be handled by a trained psychiatrist. Unfortunately, such individuals are at present expensive luxuries who could not be had even if the institution were willing to foot the bill. Hence such a program as we are using must simply be regarded as more or less of a makeshift. Most colleges will, however, have to adopt some such methods for several years to come, and it is for their benefit that this article is submitted.

USE OF PSYCHIATRIC FACILITIES IN CRIMINAL COURTS IN THE UNITED STATES

A SUPPLEMENTARY NOTE

WINFRED OVERHOLSER, M.D.

Director, Division for the Examination of Prisoners, Massachusetts Department of Mental Diseases; Assistant Professor of Psychiatry, Boston University School of Medicine

THE results of a preliminary questionnaire survey of the extent to which psychiatry is employed by the criminal courts and the penal and reformatory institutions of the United States have already been reported.[1] That survey was conducted under the auspices of the National Crime Commission, through its Subcommittee on the Medical Aspects of Crime, for the purpose of obtaining a general view of the situation, the intention being to make further and more detailed studies on the basis of the facts there revealed. The present note presents such information as became available through replies to a supplementary questionnaire which was sent by the subcommittee to the courts in the original survey that reported a regular use of psychiatry.

In the preliminary study above mentioned, it was found that 110, or 9.4 per cent, of the total number (1,168) that replied, distributed through 31 states and the District of Columbia, stated that they were served regularly by a psychiatrist, either employed by the court on a full-time or a part-time basis or furnished by some other public agency. Accordingly, a more detailed questionnaire was sent to each of these courts in the early summer of 1928. In a few instances, the questionnaire was sent to more than one justice of the same court, so that in all 115 were mailed. Up to December 31, 1928, 76 courts (66.1 per cent), had replied.

[1] *Psychiatric Service in Penal and Reformatory Institutions and Criminal Courts in the United States, by Winfred Overholser, M.D.* MENTAL HYGIENE, Vol. 12, pp. 801–38, October, 1928.

The questions were as follows:

INFORMATION RELATIVE TO COURTS

(Requested by the National Crime Commission)

Name of court Location

Scope of jurisdiction (misdemeanors, felonies, juvenile cases, etc.)

1. Is psychiatric advice available to your court through
   (a) A court psychiatrist (or court clinic)?
   (b) Or is an outside clinic used?

   If the latter, please give name and brief description (whether a state-hospital clinic, a state traveling clinic, a community clinic, etc.)
2. If a psychiatrist is regularly employed, please give his name.
   Is he on a full-time or part-time basis?
   (a) If the latter, how much time a week does he devote to the work?
   (b) Are his services voluntary?
   (c) Is he paid on fee basis, or is he paid by salary?
   (d) If paid by fees, what is the amount per examination?
   (e) What are the requirements with respect to education and experience for appointment as psychiatrist in your court?
3. Is an investigator (probation officer, psychiatric social worker, or others) available to assist the psychiatrist in obtaining information for his examination? Please specify.
   Does this investigator who assists have other duties as well in connection with the work of the court? Please specify.
4. Are mental examinations made of all accused persons or only in selected cases? If the latter, who makes the selection?
5. Is the mental examination employed with special reference to
   (a) Accused's capacity to be tried (fitness to plead, consult with counsel, etc.)?
   (b) Accused's mental condition at time of offense (*i.e.*, responsibility)?
   (c) Determination of sentence (length and place) or other disposition?
   (d) Mental fitness of convict to be executed (if your statutes make this a matter for judicial rather than executive determination)?
6. Is a mental examination made particularly in certain classes of contemplated disposition, *e.g.*, probation?
7. How many cases were examined by a psychiatrist in your court during the past year?
8. In approximately how many cases (criminal) annually do you commit the accused temporarily to a mental hospital for observation?
9. How many cases (all kinds) were disposed of in your court last year?
10. If a psychologist is regularly employed, is he on a full-time or a part-time basis?
    (a) If the latter, how much time does he devote to the work?
    (b) Are his services voluntary?

(c) Is he paid on fee basis?
(d) Please give his name.

11. Is there a psychiatric section in the annual report of the court? (Copies of recent reports would be appreciated.)
12. Are there in your state constitution or laws any limitations as to the classes of accused persons who may be examined, or as to the stage of proceedings when such examination may be made? (A discussion of this topic, with citations, would be very helpful in view of the divergent provisions in the various states.)
13. Your comment would be appreciated on the possibility of any fundamental changes in criminal procedure, whereby there may be made available to the court data in regard to the mental and physical condition, personality, and previous history of the accused, in order that these data may assist the court in arriving at decisions as to disposition. If such changes become effective, what rôle could be played by the psychiatrist, and what would be his relation to the judge?

It will readily be admitted that the questionnaire was not ideal, since the questions were numerous and could not all be answered by one or a few words. On the other hand, the judges to whom the interrogatories were addressed had already by their previous replies shown their interest in the subject, so that it was considered justifiable to be more specific and detailed than is the general rule in such inquiries.

The geographical distribution of the seventy-six courts replying was wide, covering twenty-six states, as follows:

Arkansas	1	New York	12
California	6	North Carolina	1
Delaware	1	Ohio	9
Florida	2	Oklahoma	1
Illinois	1	Oregon	3
Indiana	2	Pennsylvania	8
Iowa	2	Rhode Island	1
Kansas	2	South Carolina	1
Kentucky	1	Tennessee	1
Maryland	2	Texas	3
Massachusetts	4	Virginia	4
Michigan	4	Wisconsin	2
Missouri	1		
New Jersey	1		76

The matter of scope of jurisdiction of the various courts that employ psychiatry is of considerable interest, and was the subject of one question. The courts were found to classify as follows:

Juvenile offenses only	38
Misdemeanors only	9
Felonies only	8
Misdemeanors and felonies	4
Misdemeanors and juvenile offenses	5
All types (general jurisdiction)	12
	76

It will thus be seen that exactly one-half of all the courts that reported were of juvenile jurisdiction only. This fact suggests the readiness with which psychiatric facilities can be incorporated in juvenile-court procedure. It suggests likewise, perhaps, the desirability of extending a similar procedure to dealings with adult offenders. At any rate, it may safely be said that psychiatry so far appears to have made greater progress in the juvenile than in the adult courts.

Question 1 was designed to secure detailed information as to the manner in which psychiatric advice is made available to the court. Here an apparent discrepancy arises between the results of the former and of the present survey. In the earlier study, 24 courts reported a full-time psychiatrist, and 65 a psychiatrist on a part-time basis, whereas 21 reported themselves as served by some other public agency. It now seems likely that a considerable number of courts claimed credit for a part-time psychiatrist of their own when in reality they were occasional (or regular) clients of some outside clinic. Only four of the 76 courts in the present survey reported a full-time psychiatrist, and in one of these cases a juvenile court claimed as a full-time employee the psychiatrist of another court! Really, then, only three full-time psychiatrists were reported. On the other hand, 39 of the courts reported the use of an outside clinic. Of these, 12 use a state traveling clinic or one operated by the county, seven refer cases to the staff of a state or county mental hospital, five use a child-guidance clinic (supported by the city or by private subscription), two use other private clinics, and one a state-university clinic; the other 12 do not specify. A part-time court clinic is reported by seven courts. The remaining 26 courts either use no psychiatry at all (apparently only four are in this group), call in some physician, such as the county health officer, or appoint a commission.

The question (No. 2) as to the qualifications and remuneration of the court psychiatrist turned out to be valuable chiefly as illustrating the judges' conceptions of the requisites of a court psychiatrist. Twenty stated that the psychiatrist should be a specialist, while 45 gave no reply. The remaining 11 replies were as follows:

"None"	1
General practice	4
"Satisfaction of judge"	1
National examination	1
Psychiatry not used	4

That there is no uniformity of standards in the selection of psychiatric advisers to the courts seems a warrantable inference! No attempt is made to analyze the replies to the rest of Question 2; a number of the spaces were left blank, and the replies given cannot well be classified. It may be stated, however, that the names of 23 of the 38 psychiatrists given are not found in the roster of the American Psychiatric Association, the recognized national organization of psychiatrists.

The extent to which assistance is rendered by the probation officer or other investigator to the psychiatrist (Question 3) is materially larger in this group than was indicated by the original survey. Sixty-five of the courts stated that such assistance is available, 10 made no reply, and only one returned a negative answer.

The question regarding the selection of cases (Question 4) may be considered together with those relating to the number of persons examined (Question 7), committed for observation (Question 8), and disposed of (Question 9). Only one court, of juvenile jurisdiction, located in a Pennsylvania city, reported that all of the children coming before it are examined by a psychiatrist or a psychologist. No other court reported routine examination. The manner of selection, then, is of interest. In 29 courts, the court does the selecting, in 11 the court or probation officer, and in nine the probation officer. In three courts the matter is apparently left to the defense attorney, and in two to the prosecutor. The grounds for the selection of particular cases by these officials are not stated. Four other courts replied as follows: psychologist, 1; routine (not borne out by other statements), 1; "outside",

1; welfare department, 1. The other 17 courts gave no reply.

The forty-four courts that reported figures for Questions 7 and 9 vary enormously in the amount of business conducted by them, as well as in the proportion of cases examined. One court, for instance, disposed of 71 cases during the year preceding the return of the questionnaire, and the numbers run from this up to 34,874. Only eight, however, report five thousand cases or more, the numbers ranging generally under this amount by a considerable margin.

The percentage of cases examined (based upon the total number disposed of) is shown in the summary below. One court which gave no basic figures stated that 5 per cent of the cases disposed of were submitted to psychiatric examination. This figure has been included.

Percentage of cases examined	*Courts*
Less than 1	5
1– 5	14
6– 10	7
11– 20	8
21– 30	3
31– 40	0
41– 50	3
51– 60	2
61– 70	1
71– 80	0
81– 90	0
91–100	2
Total	45

By far the largest group (19) is made up of courts that examined less than 5 per cent of their cases, and we find 26 out of the 45 courts examining less than 10 per cent. It is, in general, the smaller courts that report the larger percentages. In this connection, it must be borne in mind that in the larger courts a very elaborate machinery must be organized if any great proportion of cases is to be examined properly without disrupting and hopelessly delaying the court routine. We may consider that the facts here presented, while not ideal, do indicate material progress.

Question 5 refers to the purpose for which psychiatric advice is desired by the court, the replies showing whether its value to the judge relates primarily to the trial or to the dis-

position of the convicted person. Of the 62 judges who replied to this question, 28 expressed themselves as interested chiefly in the aid that the psychiatrist can render in bringing about a more understanding disposition of the case. The replies follow:

Ability to stand trial	2
Responsibility	3
Disposition	28
Responsibility and ability to stand trial.	9
All three	20
Not stated	14
	76

The matter of the mental fitness of a convict to be executed is evidently one that is rarely or never brought before the courts that replied.

The question (No. 6) referring to the use of examinations in certain classes of contemplated dispositions was answered so irregularly that no analysis is attempted.

Court psychologists (Question 10) do not appear to be so numerous as the results of the preliminary survey seemed to indicate. In that survey 70 courts reported that they employ the services of a psychologist with at least some degree of regularity. Of the 76 courts covered by the present report, only 17 report that they have a court psychologist, and in only eight cases was the psychologist employed on a full-time basis. In at least three of these instances, the psychologist is used in place of a psychiatrist, no psychiatrist being reported.

The replies to Question 11 indicate that in many courts the psychiatric work is not sufficiently organized to warrant a section in the annual report of the court. In fact, one is sometimes moved to wonder how many courts see fit to render an annual report! A few of the larger courts, however, give this phase of their activities a place in their reports. That this will become increasingly the practice as the value of psychiatry is recognized seems highly probable.

The comments made in reply to Questions 12 and 13 were, in the main, of doubtful value. The tone was generally sympathetic to psychiatry, as would be expected in the selected group of judges who replied. Several courts indicated the desirability of examining all offenders, or at least those

accused of serious offenses. A few recorded their desire to employ psychiatry, but lamented the failure of the authorities to supply the necessary funds. One judge offers the valuable suggestion that "there should be a psychiatrist provided and required by the state available to every criminal court; one psychiatrist could serve a number of small district courts". It would seem that some such procedure is the only means whereby the smaller courts can be adequately provided with psychiatric facilities. The increasing use of traveling clinics by the courts indicates the willingness of the courts to be advised, and it is to be hoped that the supply of such facilities will be kept up to the demand. The mere fact that a court handles but little business and is unable to set up its own clinic certainly should not mean that it must be utterly devoid of competent medical advisers.

SUMMARY

In order to supplement the results of a preliminary survey of the extent to which psychiatry is employed in the criminal (and juvenile) courts of the United States, questionnaires were sent to 115 courts which had previously reported the regular use of psychiatry. Seventy-six courts, located in 26 states, replied.

One-half of the courts replying (38) were of juvenile jurisdiction only. The others were of varying scope of adult (or adult and juvenile) jurisdiction. The employment of a full-time psychiatrist is reported by four courts, that of a part-time psychiatrist by seven, and the use of an outside clinic by 39. The use of an outside clinic seems to be more widespread than was indicated in the preliminary study. Twenty-six courts out of the 76 seem to be casual users of a local physician, or even to use psychiatric advice almost not at all.

There is no uniformity of standards in the selection of psychiatric advisers by the court. Only 20 judges stated definitely that the court psychiatrist should be a specialist.

Only one court reports that all cases are examined mentally before disposition. Twenty-six courts examine less than 10 per cent of all cases, and 19 examine less than 5 per cent.

Cases are usually selected for examination by the court (29), probation officer (9), or by either (11). In three courts

the selection is left to the defense counsel, and in two to the prosecutor.

The value of psychiatry in indicating disposition is well recognized. Twenty-eight judges state that psychiatric advice is desired primarily with reference to disposition, and 20 others are interested in this, in addition to ability to stand trial and responsibility.

Court psychologists are fewer than was indicated by the preliminary survey. Eight courts report a full-time psychologist, and nine a psychologist on a part-time basis.

The comments suggest the desirability of providing the smaller courts with psychiatric facilities, preferably through some state agency, as, for instance, by means of a traveling psychiatrist or a psychiatric clinic.

ONE HUNDRED TRAFFIC OFFENDERS

THEOPHILE RAPHAEL, M.D.
ALFRED C. LABINE, M.D.
HELEN L. FLINN
and
L. WALLACE HOFFMAN
The Psychopathic Clinic, Recorder's Court, Detroit, Michigan

IN view of the very major problem "traffic" has now come to represent, it was felt that the clinical study of a comprehensive series of actual violators might prove of no little interest and might possibly lead to findings of really constructive moment. Through the courtesy and coöperation of Judge Thomas M. Cotter, of the Detroit Recorder's Court, who was in charge of traffic cases during December, 1928, such a study was made possible. The results of this investigation are presented herewith.

The cases referred were as far as possible unselected as to person, so as to afford as close a representation as might be of the general group of traffic offenders who passed through the court during the period mentioned. Some selection, it should be noted, was made as to type of offense, thereby insuring inclusion within the series both of serious violations and of others relatively less so, without undue weighting at either extreme. In all, 127 cases were referred. However, for statistical purposes and to obtain a homogeneous a group as possible, the first 100 English-speaking male cases, fully and satisfactorily worked up, were taken to constitute the final series upon which the following report is based.

The study included a careful psychiatric and general physical examination of each case, and such investigation as was possible as to past history and present circumstances, personal and social; also inquiry as to matters of significance in relation to traffic problems. Because of the time limit obtaining, we were dependent for certain information upon the examinees themselves, although important facts were securable through the probation and police departments. Such

error as may occur on this basis may be presumed to fall rather on the side of minimization than the reverse.

From the standpoint of charge preferred, the series distributed itself as follows:

Speeding	32
Driving while drunk	28
Reckless driving	17
Car not under control	4
Driving to left of street car	4
Leaving scene of accident	3
Failure to stop at stop street	3
Obstructing traffic	2
Cutting in on traffic	2
Improper turn	2
Driving through safety zone	1
Triple parking	1
No public-vehicle license	1
	100

As regards site of violation, the following data were secured:

Clear course	54
Intersection	41
Railroad crossing	1
Curve	1
Miscellaneous	3
	100

Forty-eight per cent of the offenses occurred during the day; also clear weather and good driving conditions obtained in 74 per cent of the cases. It would seem, therefore, in a general way, that so far as traffic difficulties are concerned, purely external conditions cannot be considered the only, or indeed even the chief, offending factor.

The age range of the 100 cases was found to be from 17 to 56 years. The distribution was as follows:

17–19 years	11
20–24 "	20
25–29 "	19
30–34 "	24
35–39 "	10
40–44 "	8
45–49 "	4
50 and over	4
	100

The median age was 30, with the greatest incidence, 63 per cent, falling between 20 and 34 years, the bulk of our group being, therefore, in the young-adult and early-middle-life periods.

Ninety-four per cent were white and 6 per cent colored. In the matter of civil status, the distribution was as follows:

Married	56
Widowed	1
Single	37
Divorced	2
Common law	1
Separated	3
	100

In this connection it may be of interest to note that 89 per cent were found, within broad limits, to be acceptably employed and adjusted to their work.

As regards educational training, it is worth noting that 5 were illiterate, 61 had passed through eight grades or less, 28 had completed or partly completed high school, and 6 were college trained.

As to residence, 82 per cent were found to have lived in Detroit a year or more (median 10.5 years), while the rest resided at points nearby. On the basis of this group, therefore, the problem would appear to be largely local and indigenous, not implicating an especially great number of transient drivers or drivers en route. In this connection it is of interest that 81 per cent claimed birth in this country.

The data on length of the individual driving period may be summarized as follows:

1–5 years	26
6–10 years	32
11–15 years	30
16–20 years	11
23 and over	1
	100

Relative to the stated daily mileage, this ranged from 0 to 200, with a median of 39 miles and the median reported

as necessary, 26 miles. From this it is evident that definitely fewer miles per day, in total, might be driven without undue individual hardship and to the proportionately greater convenience and safety of society.

The data as to licensure were as follows:

Licensed in Detroit	81
Licensed elsewhere	16
Unlicensed	3
	100

In 9 cases, it may be noted, license was stated to have been secured without examination, and in only 8 was attendance at "traffic school" reported. In over 50 per cent, we might add, license had been obtained within the past five years.

The following information was secured as regards the status of the driver with reference to the car driven:

Owner	71
Part owner	2
Friend or relative of owner	10
Lessee	2
Employee of owner	15
	100

The types of vehicles used were as follows:

Private	79
Commercial	9
Jitney or bus	3
Taxi	9
	100

These cars ranged in price from $25 to $1,852, with a median of $500. Also, in 82 per cent of the cases, the cars were reported as paid for.

With reference to insurance, none was carried in 35 per cent of the series, and in 3 cases information on this point was not available. For the remainder, the type and distribution of insurance was reported to be as follows:

Liability, Property damage, Collision	19*
Liability, Property damage, Fire and theft	6
Liability, Property damage	6
Liability, Fire and theft	3
Liability	3
Fire and theft	25

* In 10 of these cases the car was owned by a company and insurance was compulsory.

Of especial interest in this connection is the fact that "liability" seems not to have been carried in at least 60 per cent of the cases.

As regards previous legal difficulties, these ranged from 0 to 19, with a median of 2.4. This is probably rather lower than is actually the case since, except for non-traffic counts, we were dependent chiefly upon the drivers' own statements. These previous difficulties covered a wide range, thus:

Traffic Offenses

Speeding	53
Incorrect parking	33
Failure to stop at a stop street	13
Driving through red light	13
Driving while drunk	10
Traffic violation (unspecified)	9
Obstructing traffic	9
Improper turn	5
Double parking	4
Four in driver's seat	4
Reckless driving	4
No muffler	4
No public-vehicle license	3
No chauffeur license	2
Negligent homicide	2
Dirty license tag	1
Driving left of express stop	1
No tail light	1
Glaring headlights	1
No lights	1
Parking in alley	1
License plate not visible	1

Other Offenses

Disturbing the peace	14
Drunkenness	13
Violation of the Prohibition Law	5
Unlawfully driving away automobile	4
Simple larceny	4
Assault and battery	4
Violation of the Interstate Commerce Act	3
Breaking and entering	2
Grand larceny	2
Fugitive from justice	2
Disorderly person	2
Held for investigation	1
Gross indecency	1
Rape	1
Larceny of automobile	1
Embezzlement	1
Obtaining money under false pretenses	1
Juvenile delinquency	1
Violation of the Immigration Law	1
Violation of a city ordinance	1
Gambling	1

Alcoholism was found to have a seriously handicapping and disabling effect upon the driving competence of 46 per cent of our cases.

As to intelligence, the results of the psychometric tests (Stanford Revision of the Binet-Simon) were as follows:

I. Q.	*Cases*
46–59	10
60–69	21
70–79	20
80–89	22
90–99	12
100–109	9
110–118	6
	100

Considering all the factors involved, at least 12 cases were felt to be without any question diagnosable as natively feeble-minded and 42 as of inferior intelligence. Also, it should be noted that in 24 cases innate or original intellectual capacity was found to have been affected by acquired deteriorative change, in main ascribable to alcohol.

One actually psychotic individual (general paresis) was encountered. There was also one case with active epilepti-

form tendency, as well as one with a previous history of this disorder.

As regards the occurrence in really significant degree of traits definitely handicapping in personal and social relations, the following were noted:

Markedly inadequate and suggestible	48
Lacking in alertness	41
Emotionally unstable and impulsive	57
Excitable	26
Immaturity of attitude and response	14
Unreliable or undependable	28
Egocentric	31
Lacking a proper sense of responsibility	45
Actually antisocial in attitude and tendency	3

This gives a total of 293 handicapping traits for the whole group, or a hypothetical average of 2.9 per individual.

This classification admittedly has a certain impressionistic quality; nevertheless, in the hands of four trained workers, such an impression was felt to be fairly valid, particularly as only cases in which the attribute in question was very definitely apparent were admitted to the various categories. That is, the cases were scaled in accordance with the seeming severity of the specific trait, on a 0 to 5 basis, with the final inclusion only of those agreed upon in conference as falling between 2 and 5.

In addition, on the basis of a special test, a relatively simple traffic "set-up" problem, 50 of the group were found to be so slow in reaction time as to be seriously handicapped in actual traffic practice.

As regards general insight into traffic relations, as determined by performance in connection with certain specific problems and familiarity with traffic regulations, 43 per cent were noted as definitely unsatisfactory, with 31 per cent acceptable and 26 per cent doubtful. In this test, as well as in that of reaction time, the cases were rated on the basis of personal performance in relation to the group median, this representing a more liberal evaluation procedure than comparison with selected "normals", and eliminating from consideration the rather difficult and uncertain question as to just who might be validly assumed, in absolute terms, to represent the normal.

From the standpoint of associated physical defects, significant impairment in hearing was found in seven cases and noteworthy visual handicap in 14, with four instances of varying degrees of color blindness. Also, in one case the right arm had been amputated and in another the left leg, while a third was found to have a handicapping ankylosis which affected the left elbow.

Finally, after a careful consideration of each case in the light of all the criteria employed, and a liberal evaluation, a very serious question presented itself as to the acceptability as drivers of 58 of the group, from the standpoint of competency and safety to the general public and themselves. Thirteen, it was felt, might be regarded as acceptable and 29 as doubtful.

To give an idea of the type of individual in the first group, the following brief summaries of the findings in each of the 58 cases are presented here.

1. Inferior intelligence; egocentric; extremely[1] unstable; markedly inadequate; very poor sense of responsibility; very poor alertness; markedly slow reaction time. No insurance. One previous traffic difficulty. Present charge: speeding.

2. Feebleminded; markedly inadequate; markedly suggestible; extremely poor alertness. No liability insurance. Four previous traffic difficulties. Present charge: reckless driving.

3. Inferior intelligence; alcoholism with deterioration; unreliable; extremely inadequate; markedly suggestible; very poor sense of responsibility; poor alertness; markedly poor insight; visual difficulty. No liability insurance. One previous traffic accident. Present charge: driving while drunk.

4. Feebleminded; alcoholism; unstable; markedly inadequate; poor sense of responsibility; markedly poor alertness; slow reaction time; poor insight. No insurance. Two previous traffic difficulties. Present charge: car not under control.

5. Inferior intelligence; alcoholism with deterioration; very unreliable; very inadequate; markedly impulsive; poor sense of responsibility; markedly poor alertness; markedly slow reaction time; very poor insight. No insurance. One previous traffic violation: driving while drunk. Present charge: driving while drunk.

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[1] The adjectives here employed were intentionally selected so as to afford as close indication as is verbally possible of the degree in which the specific trait in question was estimated to be present. Thus *no* adjectival qualification corresponds to a numerical rating of 2, "markedly" to 3, "very" to 4, and "extremely" to 5.

6. Inferior intelligence; alcoholism with deterioration; markedly undependable; very unreliable; irritable; extremely poor sense of responsibility; poor alertness; very poor insight; ankylosis of left elbow; visual and hearing defects. Fifteen previous arrests, including one for driving while drunk, and one for reckless driving; also two for drunkenness, one for assault and battery, and one for disturbing the peace. Present charge: speeding.

7. Alcoholism with deterioration; markedly unstable; very inadequate; markedly impulsive; somewhat defective vision. No insurance. One previous arrest for unlawfully driving away an automobile. Present charge: speeding.

8. Inferior intelligence; markedly egocentric; very unstable; very poorly coöperative; markedly undependable; markedly infantile; very inadequate; suggestible; impulsive; markedly excitable; very poor sense of responsibility; unobservant; slow reaction time; very poor insight. No insurance. Two previous traffic difficulties. Present charge: speeding.

9. Infantile; alcoholism with deterioration; very unstable; very suggestible; markedly impulsive; rather slow reaction time; poor insight. No insurance. Three previous traffic difficulties. Present charge: speeding.

10. Alcoholism; egocentric; unstable; infantile; very inadequate; very impulsive; markedly poor sense of responsibility; careless; visual defect; color blindness; rather slow reaction time; poor insight. No insurance. Present charge: driving while drunk.

11. Feebleminded; alcoholic; very undependable; very poor sense of responsibility; very poor alertness; markedly inadequate; markedly impulsive; rather slow reaction time; poor insight; poor judgment. No liability insurance. Four previous traffic difficulties, and two arrests for disturbing the peace. Present charge: no public-vehicle license.

12. Alcoholism with question of deterioration; rather slow reaction time; poor insight. No liability insurance. One previous arrest, for drunkenness. Present charge: reckless driving.

13. Feebleminded; markedly suggestible; very slow reaction time; very poor insight. No insurance. One previous difficulty—drunkenness. Present charge: reckless driving.

14. Alcoholism with deterioration; very poor insight; suggestible; markedly unstable; very slow reaction time. One previous traffic difficulty—negligent homicide; also violation of the Prohibition Law. Present charge: driving while drunk.

15. Feebleminded; very undependable; very unreliable; very impulsive; very excitable; egocentric; very slow reaction time; extremely poor insight. Seven previous arrests, including four for traffic violations; also embezzlement, obtaining money under false pretenses, and assault and battery. Present charge: speeding.

16. Alcoholism with deterioration; markedly unstable; markedly undependable; inadequate; very impulsive; excitable; markedly poor alertness; poor insight. No insurance. Present charge: driving while drunk.

17. Alcoholism; unstable; egocentric; inadequate; antisocial. No liability insurance. Two previous arrests, both for drunkenness. Present charge: reckless driving.

18. Inferior intelligence; alcoholism; very egocentric; very unreliable; markedly inadequate; very poor sense of responsibility; irritable; poor alertness. No liability insurance. Present charge: speeding.

19. Markedly unstable; markedly infantile; markedly inadequate; markedly poor sense of responsibility; very impulsive; slow reaction time. Two previous traffic difficulties. Present charge: reckless driving.

20. Inferior intelligence; alcoholism; markedly unstable; markedly impulsive; excitable; very poor sense of responsibility; not alert; slow reaction time; poor insight. No liability insurance. Two previous charges of drunkenness. Present charge: reckless driving.

21. Alcoholism with deterioration; markedly unstable; markedly suggestible; impulsive; impaired vision; very slow reaction time; poor insight. Two previous traffic difficulties, including reckless driving. Present charge: driving while drunk.

22. Inferior intelligence; alcoholism with deterioration; unstable; markedly undependable; inadequate; markedly poor sense of responsibility; slow reaction time; poor insight. No insurance. Two previous traffic difficulties. Present charge: driving while drunk.

23. Acute alcoholic mental disturbance; deterioration; markedly egocentric; very unstable; markedly undependable; very inadequate; markedly excitable; extremely poor sense of responsibility; visual difficulty. No insurance. Two previous traffic difficulties, including one arrest for driving while drunk. Present charge: vehicle not under control.

24. Inferior intelligence; egocentric; infantile; markedly poor sense of responsibility. Six previous difficulties, including three arrests for unlawfully driving away automobile, one for larceny of auto, and one for grand larceny. Present charge: speeding.

25. Inferior intelligence; undependable; inadequate; not alert; very slow reaction time. Four previous traffic difficulties. Present charge: speeding. Daily mileage, 100.

26. Markedly unstable; markedly undependable; inadequate; markedly impulsive; excitable; poor sense of responsibility; slow reaction time. Two previous traffic difficulties. Present charge: leaving scene of accident.

27. Alcoholism with deterioration; unstable; very poor alertness; very slow reaction time; poor insight. Three previous traffic difficulties, including two arrests for driving while drunk. Present charge: driving while drunk.

28. Alcoholism; markedly egocentric; unstable; undependable; markedly poor sense of responsibility; slow reaction time; poor insight. No liability insurance. Present charge: driving while drunk.

29. Alcoholism; markedly egocentric; very unstable; very unreliable; inadequate; markedly impulsive; excitable; very poor sense of responsibility; antisocial trend(?). No liability insurance. Two previous arrests: fugitive from justice and leaving scene of accident. Present charge: leaving scene of accident.

30. Inferior intelligence; alcoholism; markedly unstable; markedly inadequate; slow reaction time; poor insight. No liability insurance. Present charge: driving while drunk.

31. Feebleminded; alcoholism with deterioration; very unstable; very inadequate; markedly excitable; markedly poor sense of responsibility; very poor alertness; markedly slow reaction time; poor insight. No insurance. One previous arrest, for simple larceny. Present charge: driving while drunk.

32. Early organic brain disease(?); inferior intelligence with deterioration; alcoholism; markedly unstable; very poor sense of responsibility; poor alertness; very slow reaction time; poor insight; visual defect. No insurance. Two previous traffic difficulties. Present charge: driving while drunk.

33. Inferior intelligence; alcoholism; early organic brain disease(?); markedly unstable; very poor alertness; very poor insight. No liability insurance. One previous traffic difficulty. Present charge: driving while drunk.

34. Inferior intelligence; alcoholism; markedly unstable; very unreliable; markedly excitable; poor alertness. No insurance. Three previous difficulties, including one arrest for gross indecency. Present charge: reckless driving.

35. General paresis; deterioration; alcoholism; very unstable; markedly impulsive; markedly excitable; markedly slow reaction time. No liability insurance. Present charge: reckless driving.

36. Border-line feebleminded; markedly unstable; very inadequate; markedly poor alertness; very slow reaction time; very poor insight; de-industrialized. No liability insurance. One previous traffic difficulty. Present charge: failure to stop at stop street.

37. Inferior intelligence; inadequate; suggestible; markedly poor sense of responsibility; poor judgment; visual defect; impaired hearing. No insurance. One previous traffic difficulty. Present charge: cutting in on traffic, at 40–45 miles.

38. Markedly poor sense of responsibility; markedly poor alertness; very slow reaction time. Left leg amputated. One previous traffic difficulty. Present charge: speeding.

39. Alcoholism with deterioration; egocentric; very unreliable; markedly poor alertness; slow reaction time; poor insight. No insurance. Two previous traffic difficulties and one arrest for assault and battery; once held as police witness. Present charge: reckless driving.

40. Markedly unstable; markedly unreliable; markedly poor sense of responsibility. No insurance. One previous traffic difficulty. Present charge: driving to left of street car.

41. Feebleminded; alcoholism with deterioration; markedly egocentric; markedly undependable and unreliable; markedly inadequate; suggestible; excitable; very poor sense of responsibility; markedly antisocial; slow reaction time; very poor insight. Twelve previous difficulties, including two arrests for driving while drunk, two for simple larceny, three for violation of the Interstate Commerce Law, three for violation of the Prohibition Law, one for grand larceny, and one for being a fugitive from justice. Present charge: driving while drunk.

42. Inferior intelligence; very unstable; very infantile; markedly inadequate; very suggestible; impulsive, very poor sense of responsibility; very poor alertness, poor judgment; slow reaction time; poor insight. No liability insurance. Two previous traffic difficulties. Present charge: reckless driving.

43. Markedly egocentric; markedly unstable; markedly impulsive; markedly excitable; very poor sense of responsibility; slow reaction time. No insurance. No operator's license. Two previous traffic difficulties. Present charge: speeding.

44. Alcoholism with deterioration; organic brain disease(?); markedly unstable; very inadequate; markedly excitable; poor sense of responsibility; poor alertness; slow reaction time; poor insight. No insurance. Two previous traffic difficulties. Present charge: driving while drunk.

45. Inferior intelligence; alcoholism; inadequate; poor sense of responsibility; slow reaction time; poor insight. No insurance. No license. Two previous traffic difficulties. Present charge: driving while drunk.

46. Alcoholism with deterioration; very unstable; very inadequate; very suggestible; markedly impulsive; markedly poor sense of responsibility, markedly poor alertness. Slow reaction time. Poor insight. No liability insurance. Four previous traffic difficulties and one arrest for disturbing the peace. Present charge: driving while drunk.

47. Alcoholism(?); egocentric; markedly unstable; very impulsive; markedly excitable; very poor sense of responsibility; rather slow reaction time; visual defect. Three previous traffic difficulties. Present charge: speeding.

48. Inferior intelligence; alcoholism; markedly unreliable; poor sense of social responsibility; poor alertness; very slow reaction time; defective vision. One previous difficulty: reckless driving. Present charge: reckless driving. Daily mileage, 100 miles, which he states is not absolutely necessary.

49. Organic brain disease; epileptiform attacks; deterioration; tendency to use of alcohol with marked sensitivity to same; very

egocentric; very unstable; extremely inadequate; very suggestible; markedly impulsive; very excitable; very poor alertness; irritable. One previous difficulty: driving while drunk. Present charge: driving while drunk.

50. Inferior intelligence; alcoholism; markedly infantile; very suggestible; poor judgment; markedly slow reaction time. No insurance. One previous arrest: disturbing the peace. Present charge: driving while drunk.

51. Alcoholism with deterioration; egocentric; undependable; very infantile; markedly inadequate; very impulsive; markedly poor sense of responsibility; careless. No insurance. Two previous difficulties, including one arrest for driving while drunk and one for drunkenness. Present charge: driving while drunk.

52. Unstable; markedly inadequate; very poor sense of responsibility; poor judgment; rather slow reaction time; egocentric. No insurance. Somewhat defective vision. Present charge: reckless driving.

53. Border-line feebleminded; alcoholism; unstable; markedly unreliable; markedly infantile; very inadequate; impulsive; very poor sense of responsibility; very poor alertness; poor judgment; slow reaction time; poor insight. Poorly industrialized. No insurance. Five previous difficulties, including two arrests for reckless driving and one for disturbing the peace. Present charge: reckless driving.

54. Alcoholism with deterioration; markedly egocentric; markedly inadequate; markedly slow reaction time. Color blindness. No insurance. Present charge: driving while drunk.

55. Feebleminded; alcoholism; organic brain disease(?); very suggestible; very poor alertness. No insurance. One previous arrest: assault and battery. Present charge: driving while drunk.

56. Feebleminded; extremely unstable; very inadequate; very suggestible; very excitable; very slow reaction time; poor insight; visual difficulty. No insurance. One previous traffic difficulty; also one arrest for drunkenness. Present charge: driving to left of street car.

57. Inferior intelligence; alcoholism; extremely unstable; very undependable; extremely inadequate; very impulsive; very excitable; very poor sense of responsibility; very poor alertness; epilepsy(?); very slow reaction time; markedly poor insight. No liability insurance. Eight previous difficulties, including one arrest for negligent homicide, and three for drunkenness, two for disturbing the peace, one for disorderly person, and one for driving while drunk. Present charge: driving while drunk.

58. Feebleminded; alcoholism; very unstable; suggestible; very excitable; markedly slow reaction time; very poor insight. Two previous difficulties, including one arrest for disturbing the peace. Present charge: driving to left of street car.

Analyses were made of the following special groups:

	Cases
Inferior intelligence	42
Feebleminded	12
Driving while drunk	28
"No insurance"	35
Professional drivers	19

The findings for these five groups were as follows:[1]

Group with Inferior Intelligence

No license....3 cases (This includes all the no-license cases found in the total series)
Difference between actual median daily mileage and that reported necessary....21.3 miles more than necessary (For total series, 13)
Handicapped by alcoholism....59 per cent (Percentage for total series, 46)
Slow reaction time....57 per cent (Percentage for total series, 50)
Poor insight....52 per cent (Percentage for total series, 43)
Average number of handicapping personality attributes..3.5 (For total series, 2.9)

Feebleminded Group

No insurance....42 per cent (Percentage for total series, 35)
No liability†....58 per cent (Percentage for total series, 25)
Difference between actual daily median mileage and that reported necessary....25 miles more than necessary *
Handicapped by alcoholism....58 per cent *
Slow reaction time....75 per cent *
Poor insight....66 per cent *
Previous difficulties (median)...4.1 (For total series, 2.4)
Average number of handicapping personality attributes....3.5 *

Group Charged with Driving while Drunk

No license....1
No insurance....46 per cent *
No liability†....36 per cent *
Handicapped by alcoholism....85 per cent *
Slow reaction time....57 per cent *
Poor insight....67 per cent *
Average number of handicapping personality attributes..3.8 *
Intelligence level below average..71 per cent (Percentage for total series, 54)

* Figure for total series given above.
† "No insurance" group not included.

[1] Although it is recognized that percentages based on groups of less than 100 are of little statistical value, percentages have been used in these analyses of special groups for purposes of comparison with the total series.

"No Insurance" Group

No license 2
Handicapped by alcoholism . . . . . 52 per cent *
Slow reaction time . . . . . 55 per cent *
Average number of handicapping personality attributes 3.1
Intelligence level below average . . . . . 55 per cent *

Professional Drivers

No license . . . . . 1 case
No insurance . . . . . 21 per cent *
No liability† . . . . . 1 case*
Handicapped by alcoholism . . . . . 36 per cent *
Average number of handicapping personality attributes . . . . . 2.9 *
Intelligence level below average . . . . . 42 per cent*
Previous difficulties (median) . . . . . 4 *

* Figure for total series given above.
† "No insurance" group not included.

SUMMARY

The more striking of the findings for the entire series may be listed as follows:

12 were definitely feebleminded
42 were classifiable as of inferior intelligence
1 was psychotic or "insane"
1 showed an active epileptiform tendency
3 (at least) were very seriously handicapped physically. Also, 7 showed significant defects in hearing and 14 in vision. Four manifested varying degrees of color blindness.
46 were seriously handicapped by alcoholism
3 had no license
35 had no insurance
25 more had no liability insurance
2.4 was the median number of previous difficulties
13 were acceptable as drivers on a liberal evaluation.

CONCLUSION

From the foregoing it would appear, to the extent that our group may be considered as representative, that an appreciable percentage of the traffic violators who actually come to court are hardly to be deemed adequately competent or safe drivers. Further, it would seem a permissible inference that a certain fraction, although naturally a very much smaller one, of the general driving public as well must be so regarded. Much, too, of our present traffic difficulty, it is logical to suppose, may be attributed to this fraction.

If such may be assumed to be the case, it would seem, from the point of view of prevention (the most important single approach), that not a little might be gained through increased strictness in licensure, examinations for which should include scrutiny of mental and personality traits, as well as other factors. In addition, the question of a "probational" license, covering a period of a year or six months, with final licensure accorded at the end of that time should it be felt merited, presents itself for very careful consideration. In the same way, required renewal of licenses at reasonable intervals thereafter, with a complete recheck of all factors, suggests itself as a measure that might well prove of decided value. There should also be available, as required, ready and certain means for dealing very strictly, not only with all unlicensed drivers, but with violators of regulations in the licensed group, with suspension and even revocation of license, if indicated.

Finally, it should be remembered that this study, carefully as it has been carried out, is based upon a specifically local group and is freely admitted to be of a more or less pioneer or "ground-breaking" type. In that sense, it is possibly in some measure provisional rather than absolutely final in its nature. If, however, it succeeds in directing attention to a significant aspect of an important social problem and stimulates further work along the same lines, its purpose will have been fully attained.

AN OCCUPATIONAL-THERAPY BUILDING CONSTRUCTED IN UNITS*

LOUIS J. HAAS

Director, Men's Therapeutic Occupations, Bloomingdale Hospital, White Plains, New York

IT IS an accepted fact that an occupational-therapy department cannot function efficiently much beyond the pioneer stage in the usual temporary quarters. It is also true that wherever a building is planned with only the needs of the present in mind, it is soon found inadequate. Such a building can in no way take care of future growth and the development of more intensive treatment measures. While it is possible now to benefit by the experiences of others who have planned and built special buildings for occupational-therapy departments,[1] the present high cost of construction all too frequently dictates what can be undertaken. For this reason it would appear helpful to have at the start a comprehensive plan for a complete and adequate occupational-therapy building, which could be constructed in several units as funds became available and the development of the treatment required additional floor space.

The unit plan has been applied to other forms of hospital construction with satisfactory results when careful study has been given to the development of these plans. The same method can be applied to the occupational-therapy building. The development of such a plan requires, first, a study of the hospital's average population and the need for occupational-therapy treatment that it represents. This need varies with the type of hospital. Probable or planned changes in the types of patient treated must be carefully considered, as this materially affects the number to be treated in the occupational-therapy shops. Development plans that contemplate the construction of buildings at definite periods to house increased hospital population must also be considered in estimating the

* Published simultaneously with *Occupational Therapy and Rehabilitation.*

1 See Chapters 4 and 5 of *Occupational Therapy for the Mentally and Nervously Ill*, by Louis J. Haas. Milwaukee: Bruce Publishing Company, 1925.

number of patients the occupational-therapy department must eventually accommodate. Secondly, it should be remembered that the problem of occupational therapy is largely that of adjusting its many and varied activities to individual needs. In fact, in planning a building to house the occupational-therapy department, the ultimate goal is to provide every possible facility for diversifying and individualizing the treatment as much as possible. Herein lies the grave danger of underestimating the ultimate demands that will be made upon a building. When floor space, facilities, and other treatment measures are restricted, as they naturally are when a department is newly organized, the diversity and individualization of the treatment must fall short of the ideal. In other words, while the aim is to treat each individual, existing conditions often make it possible to treat only those who can be reached by a modified group presentation of occupational therapy.

There will be many patients at first who, because of their inhibitions, may not react favorably to the limited treatment measures available at the time. As the department develops—as new crafts are added, and treatment measures become more diversified and individualized—an ever-increasing percentage of the hospital population will react favorably. Each year will record progress not only in the more precise adaptation of treatments to individuals, but also in the steadily growing demand made upon the building to accommodate more facilities and a larger number of patients. It is very essential that this progressive change in the number of those to be treated be foreseen and provided for in the planning of the building.

This change from within will be accelerated by the reaction of those interested in the patient. A successful approach to the occupational-therapy treatment of certain mental and nervous patients depends upon the coöperation of friends and relatives. The older occupational-therapy centers have not as yet obtained 100 per cent coöperation, and newly organized departments may expect at first to meet with some lack of appreciation of the need for certain constructive treatment measures. The gradual transforming of such resistance into well-directed coöperation will be reflected in the gradually increasing number that the occupational-therapy department must be prepared to accommodate.

Other questions that must be considered in determining the

number the occupational-therapy building should accommodate are:

1. Is the building planned for the treatment of men or women or both?
2. Will the activities housed in the building be the only ones presented as treatment measures, or will the schedule include, beside hall work and so forth, a separately organized physical-education department?
3. Is the building to serve a public, a semi-private, or a private hospital?

The above and many other factors must be studied in relation to the local need in order to arrive at the number of individuals the department must accommodate per day.

Having established the number and type of patients to be accommodated, the next step is to draw up the tentative floor plans. The major[1] crafts that are considered feasible for use as treatment measures, as well as the many minor activities that the equipment of the well-planned building must be flexible enough to accommodate, must be taken into account in drawing up the plans.

A knowledge of feasible occupational-therapy-treatment schedules, which will depend largely upon local conditions (such as other treatment programs), is essential in determining the number of individuals who must be accommodated at any one period. Unless the tentative and final plans are based upon a thorough analysis of actual local needs, a year or two's use of the building will demonstrate many unsuspected mistakes.

It is impossible in a single article to go into a detailed study of plans for an occupational-therapy building for more than one type of hospital. Previously published papers[2] give in detail the preliminary studies on which the tentative plans for a men's occupational-therapy building may be based.

1 Major activities are those that are carried on continuously, while minor activities are those that are more or less seasonal and carried on for short periods as the occasion arises.

2 See the following by the present author: "Planning a Men's Occupational Building for Nervous and Mental Patients" (*Modern Hospital*, Vol. 22, pp. 516–26, May, 1924); *The Backbone of an Occupational-Therapy Building for Mental and Nervous Patients* (MENTAL HYGIENE, Vol. 8, pp. 737–52, July, 1924); "The Next Stage in Occupational Therapy Development" (*Occupational Therapy and Rehabilitation*, Vol. 6, pp. 283–302, August, 1927).

Therefore it seems necessary here merely to state that a men's department of 150-bed capacity in a semi-private mental and nervous hospital may require an occupational-therapy building with a one-period capacity of about 74 or a two-period capacity of about 95.

After studying local conditions, and so forth, it may seem wise to make provision for the twelve major activities shown in the following summary, which also gives the ultimate capacity each shop will require:

Shops	*Required capacity*
Basketry	12
Weaving	5
Bookbinding	4
Printing	10
Brush making	3
Chair caning	3
Blacksmithing	2
Carpentry	8
Metalwork and jewelry	11
Concrete work	2
Radio construction	1
Total	62
Outdoor-group shop facilities in basement	12
Total one-period capacity	74
Total two-period capacity *	95

* Seventy-one per cent of those attending the first period are also benefited by attending the second period.

The equipment and shop facilities of these major activities make possible the employment of the following minor or more or less seasonal activities: circular bag weaving, flat reed chair bottoms, hooked rugs, spoon forging, concrete garden furniture, reed lamps, wood turning, tennis-racket stringing, reed furniture, circular net looms and tennis-net looms, art enameling, *repoussé* work, new equipment, cabinet work, general outdoor construction, rug weaving, and miscellaneous repair work, making a total of thirty activities planned for in this building when all the units of construction are completed and organization is fully developed.

The reader is referred to the articles previously mentioned for details with regard to the selection of crafts for treatment measures, their relative importance, the capacity required by the several shops, and the per capita floor space required. The plans here presented are based upon these data. The

completed building, which is the complete result of the construction of Units 1, 2, 3, 4, has a gross floor space on the main floor of 6,925 square feet, with a net floor space of 4,819 square feet given over entirely to shops. The basement has a gross floor space of 3,016 square feet, with a shop space of 1,258 square feet.

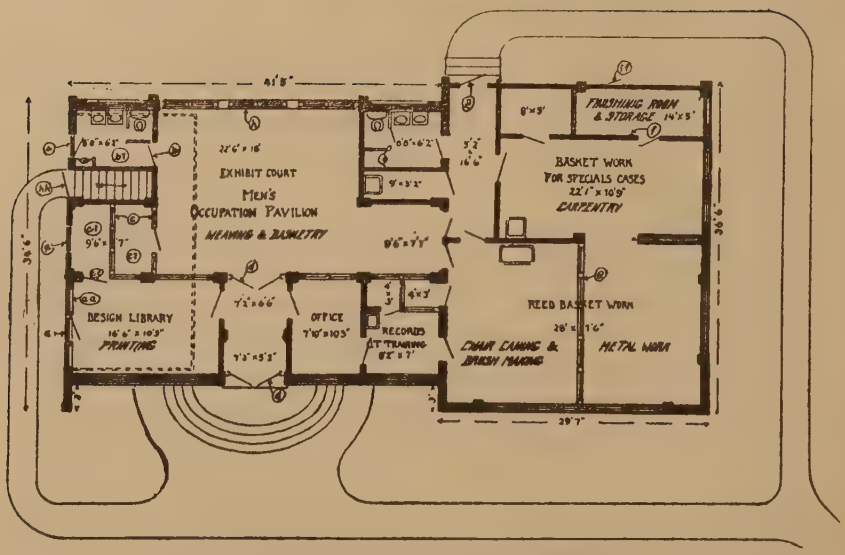
The building includes fourteen separate shops and fourteen cupboards or closets for equipment, tools, and supplies, besides an exhibit court, an office, a design library, a research laboratory, an occupational-therapy training studio, and toilet facilities. It represents 134,035 cubic feet of construction at a probable cost of 90 cents a cubic foot, a total cost of $120,631.50. This estimate is based on a structure of brick and cement with 12-foot ceilings on the ground floor and 10-foot ceilings for the basement. With the complete plans settled as the ultimate goal, but a limit of $30,160.00 for immediate construction, work may be begun on Unit 1.

Unit 1 represents in classrooms 1,525 square feet, net, and in halls, offices, closets, toilets, and so forth, 610 square feet, a gross ground-floor space of 2,135 square feet. This unit is the central section of the completed building. Construction is permanent, with the exception of certain minor temporary departures from the final plan, which make possible the functioning of the unit as a complete department. These temporary features are as follows:

The interior doorways, arches, and part partitions marked "a", "aa", "ff", and "h" are temporarily closed with glass sashes, becoming outside partitions. (See plan of Unit 1, drawing No. 1, page 830.) Temporary openings or doorways are left at "b", "cc", "f". Partitions are temporarily placed at "c" and "e". Doors are placed at "d", and the enclosed space is used as a temporary entrance court. The inside doorway "g" is used temporarily as an additional exit.

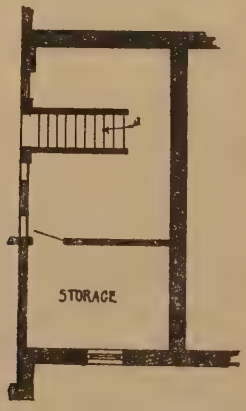
The temporary assignment of space is shown on each unit plan in italics, while for the sake of comparison the final assignment is indicated in roman type. Each temporary assignment of floor space is made in accordance with the scheme or scale of balanced therapeutic crafts planned for the completely developed department.[1] Thus, while each unit

[1] See *Occupational Therapy for the Mentally and Nervously Ill*, Chapter 4, page 46.



No. 1.—Floor plan of Unit 1, showing temporary assignment of floor space. Dotted lines indicate the basement.

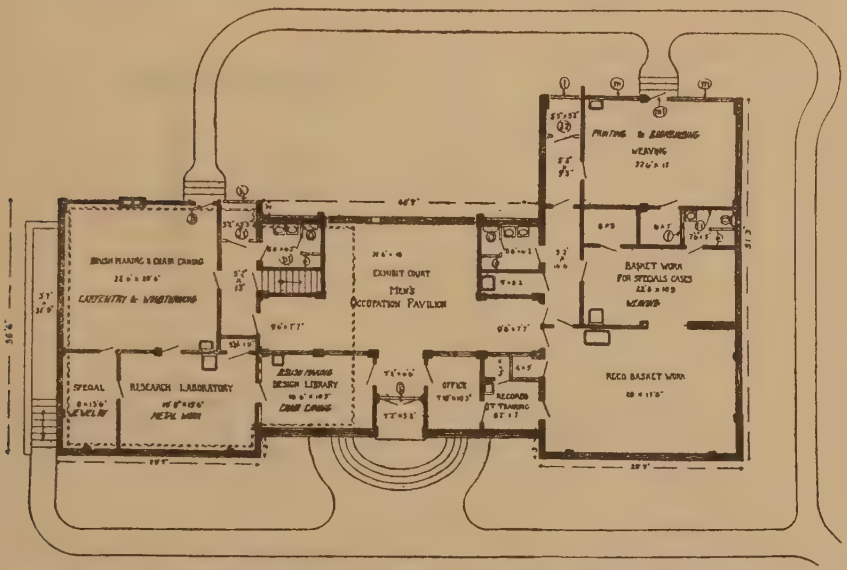
is a modification of the final therapeutic scheme, its group of crafts functions as a balanced department. Unit 1 is planned to accommodate a modified department using as therapeutic activities weaving, chair caning, printing, brush making, metal work, and carpentry.



No. 1a.—Plan of front basement constructed with Unit 1.

Unit 1 is served by a basement with a floor space of 378 square feet which is planned for the storage of large supplies. This increases the floor space of the building to 2,513 square feet. (See drawing No. 1a, above.)

Unit 1 will be outgrown by the time funds are available for the construction of the next unit. The need for more floor space and additional facilities will be increasingly apparent after the first year. Unit 2 adds floor space at each end of the initial unit. The addition represents in classrooms on the ground floor 1,174 square feet of floor space, and in hall, office, closets, toilets, and so forth 189 square feet, a gross ground-floor space of 11,363 square feet. With the completion of this addition, 692 square feet of floor space in the area of



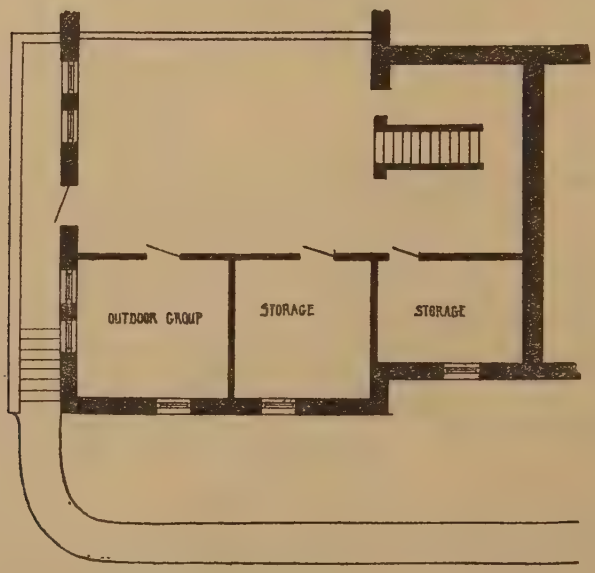
No. 2.—Floor plan of Unit 2 and Unit 1, showing the addition represented by Unit 2 and indicating the reassignment of floor space which makes possible more complete occupational-therapy facilities. Dotted lines indicate the basement.

Unit 1 that was temporarily used for other purposes is now finally assigned to an exhibit court, reducing the floor space assigned to classrooms. The 3,498 square feet of ground-floor space of the building (Units 2 and 1) represents in classrooms 2,007 square feet, and in exhibit room, halls, office, closets, toilets, and so forth, 1,491 square feet.

The construction of this addition is permanent and is in harmony with that of Unit 1. With the completion of Unit 2, all temporary departures from the final plan made in Unit 1 are now eliminated, but Unit 2 is constructed with minor temporary departures from this plan as noted here. The half-partition "m" (drawing No. 2, above) is constructed as a

full-height glazed partition. The planned interior doorways "m" and "n" are now used as temporary exists. The toilet "b1" is now completed as planned. (Compare drawing No. 1 with drawing No. 2.) Temporary partitions and doorways "k" and "l" are so placed as to produce the much needed closets "j1" and "j2". The partition "f" is now placed, and the toilet "f1" completed as planned.

The outdoor group engages in a variety of activities that are to some extent determined by hospital location, and so



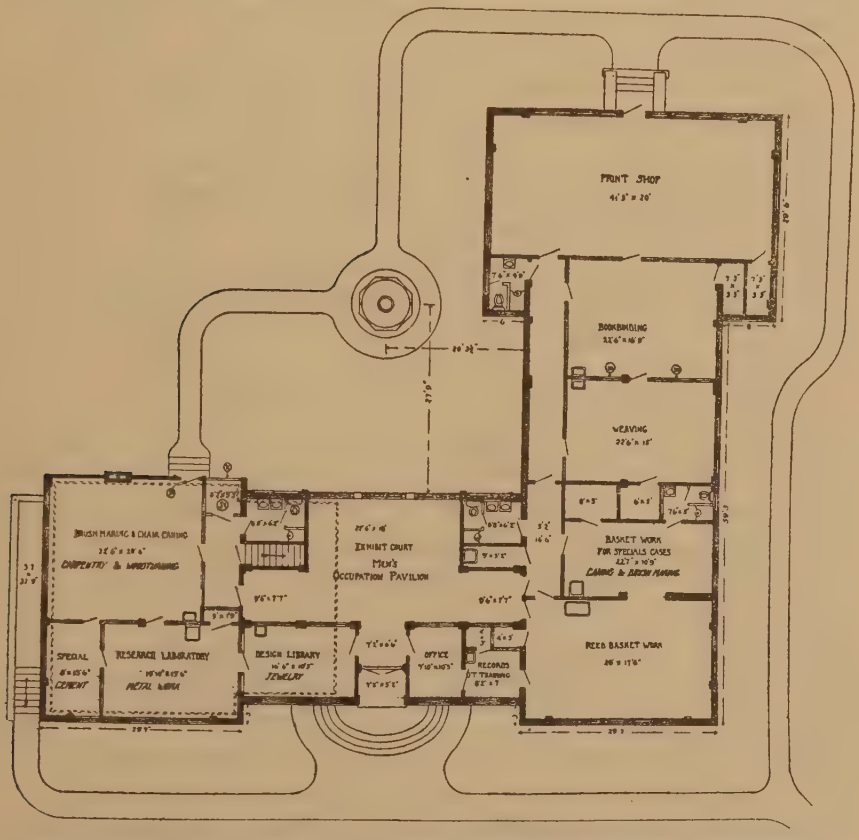
No. 2a.—Plan of enlarged basement, Units 2 and 1.

forth. This group has a tool-and-equipment room in the basement and also carries on certain activities there during bad weather. The group is considered as a part of the main occupational-therapy-building group, as will be noted. Improved facilities are planned for it as the building is enlarged.

With the construction of this unit, the basement floor space is increased 837 square feet, which is assigned as follows: classrooms 324 square feet, storage and supplies 513 square feet. (See drawing No. 2a, above.) This addition makes possible temporary classroom or shop space for the outdoor group in inclement weather and for other temporary facilities, such as a dye tank, much needed in connection with weav-

ing and basketry. This makes the total floor space of the building 4,713 square feet, gross.

Unit 3 completes one wing of the building, adding 1,368 square feet to the ground-floor space, which now totals 4,866 square feet. (See drawing No. 3, below.) No addition is



No. 3.—Floor plan of Units 3, 2, and 1, showing the addition represented by Unit 3. The reassignment of floor space indicates the reoganization of the department. There is no additional basement space.

made to the basement by the construction of this unit. The addition represents in classrooms 1,196 square feet of floor space, and in halls, closets, toilets, and so forth, 172 square feet, which increases these items to 3,203 square feet and 1,663 square feet, respectively. The building, including the basement, now has a gross floor space of 6,081 square feet.

The construction of this unit is permanent and in harmony with the preceding units. No departures are made from the

final plan in it, and with its completion the following temporary departures existing in the preceding plans are eliminated. Temporary outside partition "l" and the closet "j2" are eliminated. (Compare drawing No. 2 and drawing No. 3.) The temporary partition "m", which separate Unit 3 from the rest of the building, is replaced with an inside partition seven feet in height, composed partly of brick and partly of glazed sash.

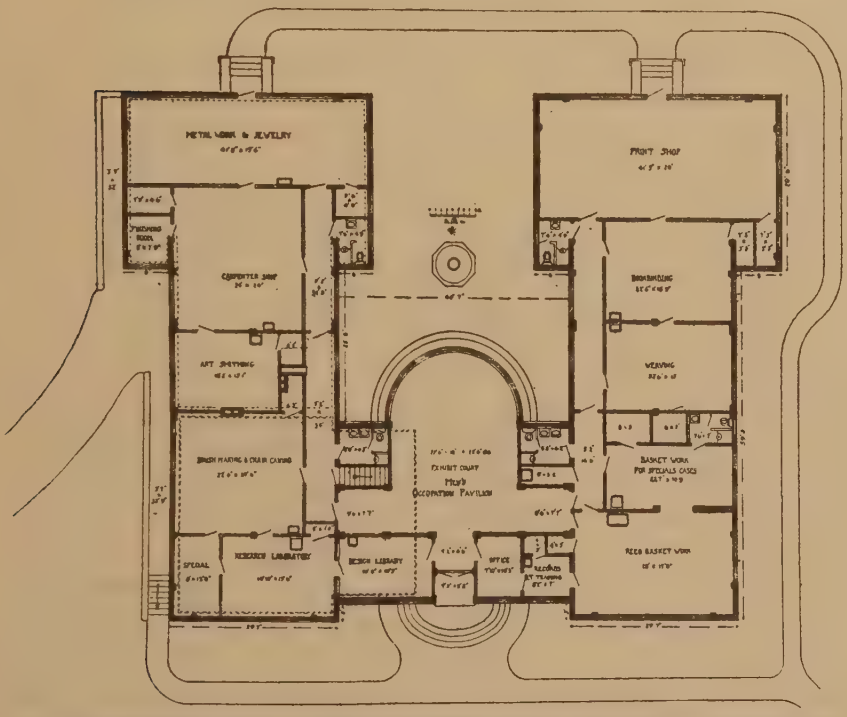
The enlarged floor space makes possible the reassignment of classrooms and the addition of these craft facilities: net-making, enameling, *repoussé*, and artistic concrete. The department now has available for treatment measures the follow-balanced group of activities:[1] weaving, net making*, basketry, chair caning, art concrete casting (basement shop)*, bookbinding, printing, outdoor work, brush making*, art-metal work, enameling, *repoussé* work, jewelry, wood turning, and carpentry.

The construction of Unit 4 adds the second wing, enlarges the exhibit court, which, being the receiving and distributing center for all patients attending the various classes, has been outgrown, and adds other needed facilities. This final addition represents in classrooms 1,516 square feet, and in exhibit court, halls, closets, toilets, and so forth, 543 square feet of ground-floor space, making the final total of these items 4,719 square feet and 2,206 square feet, respectively. The ground-floor space totals 6,925 square feet, gross. (See drawing No. 4, page 835.)

With the construction of this unit, the basement floor space is increased by 934 square feet, given over to the classrooms and a dye room, with 867 square feet for storage, supplies, incinerator, hall, and toilet. (See drawing No. 4a, page 836.) This brings the total floor space assigned to these facilities to 1,258 square feet and 1,758 square feet, respectively, giving the basement a total gross floor space of 3,016 square feet. The completed building has a total of 9,941 square feet of floor space on the two levels.

[1] Here and elsewhere in this paper activities marked with an asterisk are specially adapted for use in occupational therapy, or are new technics resulting from research work in the occupational-therapy department at Bloomingdale Hospital. See *Occupational Therapy for the Mentally and Nervously Ill*, for details of technic and plans for specially designed equipment.

When this unit is constructed, the following temporary departures from the floor plan are eliminated and no more traces of the unit form of construction remain. Temporary outside partitions "k" and the closet "j 1" are removed. (Compare drawings No. 3 and No. 4.) The temporary exit "n" (see drawing No. 3) is changed to the entrance to a closet. The classrooms are finally assigned as shown on the plan of the completed building. (See drawing No. 4.) Two of the assign-

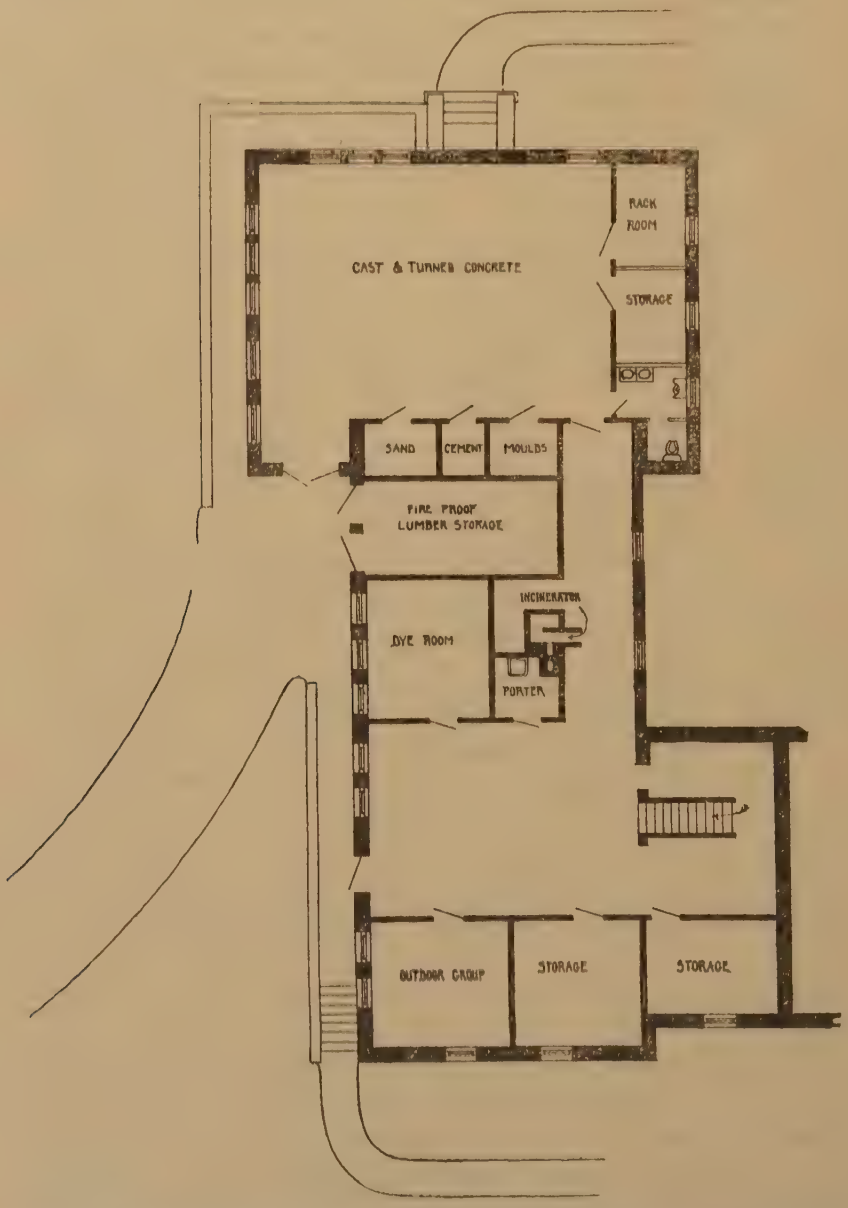


No. 4.—Floor plan of the completed building (Units 4, 3, 2, 1), showing the final addition, Unit 4. The final assignment of floor space is indicated on the plan. Dotted lines indicate the completed basement.

ments, the design library and the research laboratory, will be dealt with later.

The list of major crafts is now augmented by art blacksmithing, cabinet making, and turned concrete. The department now has the following balanced group of major activities for treatment measures: textile weaving, tennis-net making, bag-net making*, basketry, chair caning, art-metal casting*, turning* (basement shop), bookbinding, printing,

outdoor work, brush making*, art-metal work, enameling, *repoussé* work, jewelry, wood turning, carpentry, cabinet making, and blacksmithing. Definite space is designed and



No. 4a. Plan of the completed basement (Units 4, 2, and 1), showing final assignment of floor space.

special equipment is provided for the simultaneous carrying-on of all the above therapeutic activities.

A department as well balanced and thoroughly equipped as this has available equipment that makes possible the use of many minor crafts as therapeutic measures. These crafts have no permanent assignment of floor space or especial tool kit or equipment, but are made possible by the flexibility of the various craft equipments and the general knowledge of the different members of the occupational-therapy staff. All of the following activities have been frequently used in our men's occupational-therapy department. Some items in this list are so regularly used that they might be considered major activities except for the fact that they meet the need of such a limited number of patients. One activity, tennis-racket stringing and repairing, as a result of local conditions (7 outdoor tennis courts, 2 gym-floor tennis courts, and a squash court), is not seasonal here and has special equipment and floor space.

The minor therapeutic crafts and activities consist of spoon forging*, tennis-racket stringing and repairing, mechanical drawing and designing, miscellaneous repair work, radio construction, electrical wiring of occupational-therapy products, care and repair of golf equipment for the physical-education department of the hospital, repair and upkeep of all occupational-therapy equipment, machine turning of unusual metal parts frequently required in producing special occupational-therapy equipment, and the upkeep of all metal tools used in art-metal work, construction of specially designed occupational-therapy equipment, circular bag weaving*, reed furniture, and many activities so transitory that they may be listed as miscellaneous.

The assigning of definite and ample floor space to the design library and research laboratory are decided steps toward a more therapeutically efficient, more precise, and more extensive presentation of occupational-therapy treatment. The design library contains files of designs and photographic records of work produced in the department, design material and inspirational material gathered from magazines, and other material that may be of assistance to the staff in planning the various original projects. The library is

equipped with drawing tables, one assigned to each member of the staff. Thus the instructor not only finds inspiration for new designs, but also has at hand facilities for using efficiently the short preparation periods or other periods he may find for this most important part of occupational-therapy administration. Here he begins work on a new design with the minimum of time lost in getting under way, leaving the unfinished work upon his drawing table, where it will be undisturbed until he is able to take up the work again, as this room is used only by the staff. Here the director can spend undisturbed long periods of time working on important projects that require his immediate attention, with all the material that can be of assistance readily available.

Occupational therapy has been much enriched by certain research work, especially that study which has done much to adapt certain equipment, material, and technic to individual treatment needs and in many instances has produced new technics, equipment, and so forth, designed to meet requirements peculiar to occupational therapy. Therapists who are interested in work of this nature have given freely of their thought and effort, using such equipment as for the moment was free, and frequently the interest and coöperation of certain patients has been enlisted in carrying researches to a successful conclusion. Certain convalescent and coöperative patients derive a highly therapeutic form of satisfaction from aiding in such work. There are times when the regular equipment may not be free or in condition to use; also certain studies require the exclusive use of equipment for long periods of time and the entire attention of the therapist. A research laboratory is, therefore, a vital asset of the well-organized department. Placed adjacent to the design library, these files are easily accessible. The laboratory will be equipped with a complete unit of tools and equipment for each craft and certain special and general tools which will make for flexibility in the study of many problems. As the laboratory would be available only to those members of the staff who are interested in such work, the equipment should always be in condition for careful research work.

ABSTRACTS

THE NEED FOR PUNISHMENT AND THE DEATH INSTINCT. By Franz Alexander. *The International Journal of Psycho-Analysis*, 10: 256–69, April-July, 1929.

This paper discusses two explanations of those apparently irrational forms of human behavior whose purpose is the infliction of pain or injury upon the agent himself. One is that advanced by Jones, Reich, and others, who hold that self-destructive behavior results from a turning inward of the destructive forces originally directed outward. The other is Freud's theory of a primary impulse toward self-destruction, the so-called death instinct, from which outwardly directed destruction is derived.

Alexander concedes that the first theory explains a great deal of self-destructive behavior. Paradoxically, such behavior frequently represents an attempt of the ego to purchase the right to pleasure by undergoing pain. Early in its experience with external reality, the ego learns that the way to pleasure lies through renunciation, endurance, and suffering. It is not surprising to find it applying this lesson in its relations with the super-ego, which, as a representative of social demands, is in effect a bit of internalized reality. That is, the ego, obedient to the hard-learned law that pleasure is to be attained only by temporary endurance of pain, voluntarily subjects itself to certain instinctual inhibitions, or even to actual suffering, in order to secure certain instinctual gratifications. This behavior of the ego toward the super-ego in accordance with the reality principle is best seen in pathological states in which the ego and the super-ego are sharply opposed to one another.

But apart from these self-destructive psychic processes that are logically traceable to the operation of the pleasure principle, there are forms of behavior in which the self-imposed suffering seems to have lost its rational character as a tactical means to pleasure and to have become an end in itself. The ego seems as it were to be paying beyond the point where payment is necessary. In such behavior Alexander sees the possible operation of an endogenous impulse toward self-destruction or death instinct.

To prove the existence of such an instinct empirically is, he admits, impossible. It would be necessary to isolate and measure the various known factors that enter into the situation—the effect of the destructive tendencies turned inward by the resistance of reality, and so

forth—and to show that they are not enough to account for the intensity of the self-destructive activity; and psychology has no scales for such measurements. But he finds circumstantial evidence of an impulse toward self-destruction in those psychological situations in which the ego definitely betrays the interests of the id to ally itself with reality, as when the scientist sets love of truth above personal advantage or the individual sacrifices himself for the community.

It may be objected that such cases can be explained without postulating a death instinct—that they may be due to a weakening of the psychic apparatus through a strong outflowing of object libido so that it succumbs more readily to the hostile pressure of the external world and to its own aggressions turned back upon itself. Here again exact measurements of all the forces involved would be necessary to prove the existence of a death instinct. But at all events, there is a regressive principle at work in the psychic apparatus analogous to that going on in the biological molecule. As the living molecule in the process of growth is constantly taking in chemical combinations charged with disintergrating tendencies, so the psychic apparatus, in every act of identification with external reality, is admitting into itself hostile tendencies which reinforce the destructive effect of aggressions from without and play their part in the process of destruction.

Recent Methods in the Treatment of General Paralysis. By Henry A. Bunker, M.D. *The American Journal of Psychiatry*, 8:681–94, January, 1929.

Dr. Bunker sums up here the results of the tryparsamide treatment of general paralysis and the results of treatment by malaria as reported in the literature. Of 542 tryparsamide-treated cases reported on by various observers, full remission of mental symptoms and restoration of the patient to approximately his former status occurred in about 35 per cent. Clinical improvement, when obtained, is almost invariably found to outstrip serological response. While some 30 injections usually produce the maximum of clinical improvement that the drug is capable of bringing about in any given case, upwards of 100 injections are often necessary to modify materially the strength of the Wassermann reaction in the spinal fluid.

Of the malaria-treated cases on which reports have been published, a total of 2,460, full remission ocurred in about 27 per cent and incomplete remission in an additional 26 per cent. If one assumes that the cases of incomplete remission differ from the more satisfactory cases not because the therapeutics *per se* have been less efficient, but rather by reason of adventitious, extra-therapeutic factors, Dr. Bunker

feels that "the malaria treatment may justly be said to exercise a potentially 'curative' effect upon fully 50 per cent of unselected patients with general paralysis". Women seem to respond to it better than men, but this difference may be more apparent than real.

Unaided by supplementary specific treatment, malaria is capable of a definite influence upon spinal-fluid pathology, but this influence is very gradual in its manifestations, especially in the case of the Wassermann reaction. The seeming arrest of the disease process brought about by malaria may be of protracted duration. Of the cases cited in the literature as having been subjected to post-treatment observation, three out of a group of eight patients had maintained full remission at the end of from six and a half to seven and a half years, 13 out of a group of 25 at the end of nearly five years, and 21 out of a third group of 29 at the end of from four to five years.

Follow-up Investigation of Five Hundred Children Who Previously Attended Classes for the Physically Handicapped. By Jessie M. Lightfoot. *The Psychological Clinic,* 18:1–16, March-April, 1929.

The cases reported on here consist of children from the orthopedic, deaf, sight-saving, and nutrition-tuberculosis classes in the Philadelphia public-school system. The aim of the investigation was to find out to what extent physical handicaps interfere with ability to earn a living, into what type of work the "handicapped" tend to drift, and to what extent personality difficulties affect their success in industry.

Of the 500 cases visited, 38 were dead and it was impossible to locate 168. Forty-six of the remaining 294 were still in school, having been returned to the regular grades; 28 were in hospitals or institutions; and 14 were married. Five owned small stores or businesses of their own, and 134 were employed—8 in domestic service, 60 in factory jobs, and 66 in various other jobs, mostly of an unskilled or semi-skilled nature. Sixty-seven were unemployed. The highest proportion of unemployed—38 out of a group of 111—was found among the orthopedic cases. Eleven of the 51 deaf were unemployed, 12 of the 73 from the nutrition-tuberculous classes, and 6 of the 59 from the sight-saving classes.

From the data available on these cases, the author concludes that, with the possible exception of the orthopedic group, the physical handicap was not of primary importance in industrial failure. Even in the case of the crippled, such failure was due less to the defect than to inertia and emotional attitude toward work—a feeling that the world owed them a living without any effort on their part. Jobs were

obtained largely through friends and were accepted as a rightful due regardless of the efficiency of the applicant. This attitude was encouraged in the home, where the family apparently accepted the unemployment of the handicapped member as a matter of course, even though ill able to support him.

A Note on the Influence of Psychoanalysis Upon English Education During the Last Eighteen Years. By Barbara Low. *The International Journal of Psycho-Analysis,* 10:314–20, April-July, 1929.

A little over eighteen years ago a paper by Ernest Jones appeared in the *Journal of Educational Psychology,* advocating the application of psychoanalysis to educational theory and practice. In the present article, Miss Low considers how far the suggestions made and the hopes expressed in that paper have been fulfilled. She finds that while psychoanalysis as a theory is still little accepted by English educators, the influence of its concepts is apparent in every important work on educational psychology that has appeared since 1910. Even those educators who are critically opposed to it acknowledge its claims to serious attention. In educational practice also, there has been a very evident swing toward the principles set forth by Jones in 1910. For example, Jones laid it down as essential that education must be made more individual, that it must cease to concern itself exclusively with the child's intellect and give more attention to his human side, that it must take a more enlightened attitude with regard to the sexual life of the child, that in general educators must "learn to stop doing harm" before they can begin to learn to do good. All these principles have won wide acceptance and an effort at least is being made to put them into practice.

BOOK REVIEWS

THE MEDICAL DEPARTMENT OF THE UNITED STATES ARMY IN THE WORLD WAR, VOLUME X: NEUROPSYCHIATRY. IN THE UNITED STATES, by Colonel Pearce Bailey, M.C., Lieutenant Colonel Frankwood E. Williams, M.C., and Sergeant Paul O. Komora, M.D. IN THE AMERICAN EXPEDITIONARY FORCES, by Colonel Thomas W. Salmon, M.C., and Sergeant Norman Fenton, M.D. Prepared under the direction of Major General M. W. Ireland. Washington: Government Printing Office, 1929. 543 p.

As a part of the monumental history of the medical department of the United States Army in the World War, Volume X, on neuropsychiatry, has made its appearance. It is an unusually interesting and well written account of what is probably the most extensive formal neuropsychiatric activity ever organized, at least so far as the United States is concerned.

The book is divided into two sections. The first, of two hundred and sixty-nine pages and nine chapters, is devoted to activities in the United States; the second, also of nine chapters, describes the work in the American Expeditionary Forces. Scattered throughout the book are eighty-eight tables and seventeen charts. The appendix includes a copious bibliography of American contributions to war neuropsychiatry.

As the Introduction and first chapter point out, even before the United States became involved in the war, it was realized, from the experience of other countries, that neuroses comprised a comparatively new and decidedly formidable medico-military problem. Early in 1917 the Surgeon General of the Army invited a committee of eminent civilian neuropsychiatrists to Washington to confer upon this subject. "This committee was a part of a larger group, formed by The National Committee for Mental Hygiene, for the purpose of studying the possible neuropsychiatric needs of the United States Army in the event of our country's entering in the War." The recommendations of this committee, in the form of a letter to the Surgeon General dated April 12, 1917, are included in the appendix, as well as a report of one member of the committee on the "care and treatment of mental diseases and war neuroses (shell shock) in the British Army". It is fortunate that neuropsychiatric needs were so well recognized early in our preparations, and that the program recommended by this committee was practicable and eventually so

thoroughly applied. Considering the ordinary obstacles of official routine, it is, indeed, rather astonishing that the program was so successfully carried out.

The first chapter describes the steps that led to the organization of activities, including the formation of the Division of Neurology and Psychiatry of the Surgeon General's Office and the devising of special report forms.

The discussion of personnel, in the second chapter, is particularly interesting. One is accustomed to analyses of cases by psychiatrists, but considerations of specialists themselves by those competent to evaluate and express an opinion are comparatively infrequent. It is, therefore, novel, refreshing, and possibly conducive to whosesome self-analysis to meet with a frank expression of opinion as to the relative characteristics and qualifications, on the one hand, of neurologists, more aggressive and individualistic, but with little experience with the insane or with administration, and, on the other hand, of psychiatrists, trained administrators, experienced in the treatment of the insane, adapting themselves to the military situation as a body of men rather than as individuals.

It is interesting to note the opinion that it was a mistake to accede to the demands of the A. E. F. for more specialists, necessitating as it did a relaxing of strictness as to qualifications. "It would have been wiser to have refused to accept for special service all who were not sufficiently qualified professionally." Perhaps such a policy would have been impossible under the exigencies of the situation. At any rate, through training centers to which officers were detailed for instruction, neurologists tended to become better informed as to psychiatry and psychiatrists as to neurology. Physicians with inadequate preparation in both fields, if ambitious, tended also to become sufficiently informed to work under supervision. The general result of the closer association of the two specialists with common centers of instruction was the new term "neuropsychiatry", a happy combination. On November 6, 1918, there were actually in the service 630 neuropsychiatrists (253 of whom were overseas) with 128 others "under orders", including internes and inactive officers. This second chapter also outlines policies and accomplishments in the matter of contract surgeons, nurses and attendants, and psychiatric aids. The latter were the forerunners of the psychiatric social workers who have, since the war, become so generally recognized as specialists in their particular field.

Chapter III is devoted to a description of provisions for the care of mental and nervous diseases, including neuropsychiatric wards in base hospitals and general hospitals, the classification and distribution of overseas patients, and the neuro-surgical cases.

It is significant of the status of psychiatric knowledge among general medical men that certain prejudices had to be overcome, such as the idea that segregation and restraint are necessary concomitants of treatment of the insane. In fact, the statement is made that while officers of the regular medical service and line officers in most instances gave their support to the neuropsychiatrists, the officers of the medical reserve corps, commissioned from civil life, were the least coöperative.

In Chapter IV, the principles underlying neuropsychiatric examinations in the detection and elimination of individuals with nervous or mental disease are discussed. Probably, from a military standpoint, the neuropsychiatrist was of value fully as much for his elimination of persons suffering from border-line conditions as for his detection of those with frank psychoses or defects, men who would in all probability have been ultimately discharged as inapt under the provisions of paragraph 148½ A. R. for physical disability or by court-martial. For instance, it was soon determined that psychopathic individuals had no place in development battalions, but should rather be returned to the community as persons who could not be made into soldiers.

In Chapter V, methods of observation and treatment are outlined, including such special and essential agencies as hydrotherapy, occupational therapy, and psychotherapy, with an account of their successful application in the neuroses.

Chapter VI deals with the question of delinquency, surveys of prisoners, intelligence ratings in the various crime groups, and the conscientious objector.

Chapter VII is a discussion of the methods of disposition of mental cases in accordance with army regulations, the coöperative arrangements with the civil authorities of the various states, care in government hospitals, and the function of the Bureau of War Risk Insurance in relation to the insane.

Chapters VIII and IX are largely statistical. In Chapter IX, the 69,394 neuropsychiatric cases reported to the Surgeon General's Office are intensively analyzed with appropriate tables, as to officers and enlisted men, also as to white and colored races.

Section II, devoted to a discussion of neuropsychiatric activities in the A. E. F., while to some extent a continuation of the topics begun in Section I, presents in detail much important matter as to the characteristics and treatment of the neuroses. Not only from a military standpoint, but also in relation to the psychoneuroses of civil life, the discussion of case histories, detailed descriptions of treatment, and summaries of results are extremely valuable.

The first eight chapters deal, respectively, with the organization of activities; division corps and army neuropsychiatric consultants;

army neurological hospitals; the organization and administration of the hospital for war neuroses; war neuroses as a medico-military problem; the care and disposition of cases of mental disease; activities in the Army of Occupation; and a study of case histories of a typical group of war neuroses. The final chapter is a post-war study of a group of war neuroses.

The limitations of a review are entirely inadequate to do justice to the subjects covered in either of the two sections of this volume, especially the part dealing with the psychoneuroses. The latter constitute an ever-present problem in civil life and this account of a military experience with them is worthy the careful study of the practicing neuropsychiatrist. The work of the army neuropsychiatrists, as so comprehensively described in this volume, speaks for itself. It should insure the continuation and further development of neuropsychiatric activities, not only in the army, but in other organized fields.

WILLIAM C. SANDY.

Bureau of Mental Health,
Pennsylvania Department of Welfare.

CAPITAL PUNISHMENT IN NORTH CAROLINA. (Special Bulletin No. 10) Raleigh, N. C.: The North Carolina State Board of Charities and Public Welfare, 1929. 173 p.

The electric chair in North Carolina kills mentally diseased, feebleminded, and psychopathic people. It does not kill the normal and the "sane"—the men who, in the psychology of Mr. Everyman, are "responsible". It kills those who, in Mr. Everyman's psychology, are not responsible.

Without quarreling here over this use of the word responsible, we may remark that this raises interesting questions. If the electric chair kills the mentally diseased, feebleminded, and psychopathic, just how far does it act as a deterrent? Case histories of some of these offenders are given in this report. Reading them, one finds it hard to conclude that these people had any *mental ability to refrain from committing their acts;* they seem, on the contrary, to have been carried to their crimes by conditions or forces within them too strong to be checked, and no vision of the electric chair, it seems, would have held them back. How, then, can the electric chair deter others in the grip of the same or similar forces?

Or are we reduced to a situation in which we kill the mentally diseased, feebleminded, and psychopathic in order to deter the mentally healthy and normal?

There is, of course, the third possibility: that the electric chair is pure vengeance.

This study, by the North Carolina State Board of Charities and Public Welfare, is an illuminating document. It affords a detailed picture of capital punishment, and probably the commissioner, Kate Burr Johnson, deserves most of the credit for this. Not only does it present some history about capital punishment, but it tells facts about the prison population as a whole and reprints graphic newspaper accounts of electrocutions. Twenty-six persons condemned to die were studied. There is a chapter on justice by executive clemency and another on lynching and mob violence.

The death penalty is retained for four offenses in North Carolina: murder in the first degree, rape, arson, and first-degree burglary. This in itself is exceptional. From March, 1910, to January, 1928, 94 persons were killed—71 for murder, 21 for rape, and 2 for burglary; none for arson. Total death sentences were 200, but of these 100 were commuted and six prisoners were awaiting new trials.

Of the 94 killed, 81 were Negroes. "If the racial aspect of this study seems conspicuous", says the report, "it is because it inevitably enters largely into this question in a Southern state". Of the 200 condemned to die, 149 were Negroes. Thus, it appears that 66.7 per cent of the white persons condemned received commutations of sentence, and 44.3 per cent of the Negroes. In the population as a whole, the Negroes are 30 per cent.

"Howdy, you all", said Jim Collins as he stepped into the death chamber, and the way in which some of these doomed men act at the last moment is itself a study. Some repeat prayers after the chaplain; some make up prayers of their own. Some call upon Jesus to stand by them, and others invite everybody present to "meet them in glory". This report does not tell the story—as did Warden Lawes in his recent book, *Life and Death in Sing Sing*—of the tuberculous prisoner who, knowing that his end was coming anyhow, kissed the chair as he stepped into it; but it does give us an instance of a prisoner who, gazing calmly at the men rapidly putting straps to his head and legs, said: "Take your time; I'm in no hurry."

And the fighting of the crowds to get in to some of these electrocutions! It almost seems as if, were executions held in public as they used to be, we should have acres and acres of people watching—as formerly happened. "As the stench of the burning flesh pervaded the little room", runs one account in this volume, "the sheriff lit a cigar that would permit the rivalry of no other odor. 'Well, that's the end of the Garwood case', said the sheriff as the current caught the Negro. 'Somebody lend me a match, my cigar's out.' "

Twenty-six men condemned to die were studied—and quite full case histories are given. We may quote from the conclusions: "The

most striking fact brought out by these case histories is the prevalence of mental deficiency among the prisoners convicted of capital crimes, a considerable proportion of whom were executed. There are, moreover, several cases of actual insanity among them, and it is safe to say that in the 26 case histories studied, hardly one is the history of a normal man. . . .

"What is happening at present in North Carolina, as probably in most of the other states, is that the death penalty in a large majority of cases is inflicted upon the subnormal and the psychopathic who, through their innate deficiency or abnormality, are unable to cope with their environment, and many of whom from birth are predisposed to the commission of crime.

"Aside from its injustice, this is a very questionable method of treating the mentally defective. These histories suggest primarily a more constructive, state-wide program of prevention for dealing with the members of this group; clearer recognition of such deficiency, and more adequate institutional provision, if not sterilization as well."

The mental diagnosis in each case may be interesting. Nine were classed as feebleminded. Of the others, the words of the diagnoses are as follows: cerebral arterio-sclerosis; manic-depressive psychosis; definite psychosis, probably paranoid dementia praecox; chronological age thirty-three years, mental age 10 years, 4 months, I.Q. 65; chronological age twenty-one years, mental age 13 years, 4 months, I.Q. 83; subnormal or retarded; mentally retarded; catatonic dementia praecox; probable subnormality in general intelligence with psychopathic condition; subnormal in general intelligence and decidedly psychopathic; chronological age thirty-eight years, mental age 11 years, 9 months, I.Q. 73; high-grade imbecile and epileptic; feebleminded with psychopathic tendencies; feebleminded, high-grade moron; feebleminded—moron type; subnormal in general intelligence and decidedly psychopathic; paranoid dementia praecox.

Such is the course of capital punishment in North Carolina. It cuts a tiny swath through the ranks of the mentally diseased and deficient. Evidently society does not use this sword of destruction with the precise effect that many attribute to it.

Meanwhile, we must praise the North Carolina state board for issuing this report. The document is honest and searching—and required official courage. Few states, we think, would hold a similar mirror up to themselves, though now that North Carolina has taken the lead, others may be found to do so.

WINTHROP D. LANE.

The National Committee for Mental Hygiene.

RACE ATTITUDES IN CHILDREN. By Bruno Lasker. New York: Henry Holt and Company, 1929. 394 pages.

Why did not this book come before? is the question with which one lays it down. The answer is, It couldn't have. Perhaps even now it is ahead of its time, belongs really to the future. It could not have come in an age that did not consider attitudes important. In our day, even the colossal anachronism of a World War cannot be carried forward without the expenditure of vast sums for morale. The explanation of the revolt of desperate men in prison is to-day in terms of the creation of attitudes of hopelessness in those who have nothing to lose. We are beginning to see that the problem of the "repeater" in crime is a problem of mishandled attitudes.

In our day, as never before, comes the realization that peace is important, and that peace for the favored few cannot be built upon the discontent of millions. Once it might have been possible to keep from those whom the world exploits the knowledge that anything better could exist for them. Now isolation is impossible and voices of protest cannot be stifled. Along with the passing of isolation goes the comfortable belief that attitudes denied expression are thereby killed. We now know that they are not, but that they carry a sinister meaning for the peace of the world, no matter whether they exist among the patient masses of the Orient or the submerged populations of the magnificently cruel cities of the West.

The realization is dawning that if we want a secure and lasting peace, it must be achieved through the application of intelligence. Force of arms, prison, torture, death itself have never succeeded in eradicating attitudes that carried the rumble of discontent with injustice and exploitation. The attitudes of condescension and arrogance that have been deemed the personal prerogative of those who could afford them have been found to be something that no man can afford, and that no body of citizens of this closely-bound-together modern world can afford to let its possessor enjoy. For, after all, the bitterest hatreds grow, not out of economic disadvantage or even physical violence, but out of the sense of being despised, regarded as of little worth. How may intelligence be applied to the intricate problems of human relationships at the crucial points where social friction warns that something is wrong?

Race Attitudes in Children embodies the results of a study begun in 1925 by The Inquiry, "a national organization for the promotion of coöperative studies of problems in human relations". Bruno Lasker, the author, who directed the investigation, has written the report in a form suitable for use in discussion groups. Indeed, the study itself was shaped in discussion groups composed of parents,

teachers, social workers, and church workers—people who felt some concern on the subject of race attitudes because of being in a position to influence them, but not knowing how to do so by any means that would stand the test of scientific thinking. The fifty or sixty people who took part in the correspondence centering around the questionnaires represent, therefore, the group thinking of a much larger number scattered over the United States.

The study starts with the proposition, based on earlier inquiries, that "on the whole, attitudes rather than policies determine the relations between different racial and national groups in American life", that definite attitudes concerning race become evident at an early age, that they seem to spring only in part from the experiences of the individual and to be largely absorbed from the environment, and that they tend to be theorized about later in life, but in such a way that only confused and contradictory pictures of their origin result. The study takes up four questions: What race attitudes do children have? How are race attitudes acquired? How are race attitudes taught? How may race attitudes be modified? It limits itself to the consideration of attitudes where these are recognized as a problem by parents or others who are in close touch with children. It frankly disclaims any such scientific accuracy as carefully guarded tests in a psychological laboratory might produce.

The whole approach is, however, so valuable a contribution to the literature of studies of this kind that any one interested in methodology should not fail to read the author's own description of his method, from which certain excerpts are quoted:

"Objectivity was to be secured in a certain measure . . . by setting side by side experiences of a similar kind as recorded by persons in socially and ethnically different environments and with different cultural backgrounds and interests. In this way, it was hoped, a view of the situation might be built up which, without claiming accuracy for every quoted detail, would have authenticity in its larger outlines.

"This method of approach . . . provided we do not claim for it too much . . . may in the present state of our ignorance even be considered safer than refined methods of research that aim at a direct and precise ascertainment of attitudes and their causes, but are as yet far from sufficiently tested. The present literature of social psychology shows a growing awareness to the dangers of relying too firmly on findings produced with inadequate instruments of inquiry. Lacking an established technique, we need not, therefore, apologize if we begin by collecting the ores of experience from which we may hope to pan at least some few gems of real understanding. Moreover, since this study, like every worth-while social study, is

made with a view to the formulation of programs of action and of education, the insight which it may afford into prevailing 'attitudes on attitudes' . . . will be a useful by-product.''

Beyond its contribution of a valuable method for study of such complex phenomena as those of race attitudes, this book is dynamic in its freedom of approach to a situation usually weighted with the prejudices of those who set out to study without bias the attitudes of others. Race attitudes are important to the group sponsoring the study (else why expend the enormous labor involved in the careful working over of such a vast amount of data?), yet one of the major findings of the book is that the problem is not that of race attitudes, as such and apart from other types of social attitudes, but is a problem of prolonging the period of responsiveness of childhood, now so limited by the impact of the folkways and the stereotyped thinking of the adult world. The author finds that the values to be saved in better interracial understanding are the same values for which the whole modern educational movement stands—keeping young minds flexible, open to new information, courageous toward new experiences. Throughout the discussion, there is a refreshing freedom from any tendency to center attention exclusively upon the effect of racial prejudice on the group toward which it is directed. It is the warping of mind, the stunted growth of personality in the group that thinks itself above any harm from the prejudices that it harbors which, seen in this perspective, is a matter of equally great concern.

When he comes to discuss ways of modifying undesirable racial attitudes, Mr. Lasker does not feel that the elimination of conflict of standards is necessarily a good thing. Even though the study showed the confusion in children's minds which resulted from contrary teachings, intended or otherwise, given them by home, school, or church, Mr. Lasker thinks that an attempt to disguise such discrepancies is futile. ''Life is conflict and the child must learn to face life.'' He deplores the ''patchwork'' that results when people try to change attitudes by substituting others ready furnished, so that the child gains nothing in alertness of mind, but is habituated to an intellectual life which ''will consist in a series of conversions from one prejudice to another''.

Recognizing a demand for ''constructive suggestions'' for dealing with the puzzling situations created by children's attitudes about race, Mr. Lasker takes up some methods that have been tried, but again warns that what is needed is not ready-made plans to apply, but much courageous experimentation on the part of parents and teachers who are willing to try to restore in themselves some of the flexibility of mind which they would keep alive in the young.

Discussing what the school may do, the author shows that nothing

is more absurd than to try to convey as a verbal lesson what should be a new attitude of mind permeating all human relationships.

"In comparison with the educational force of a teaching that keeps the mind spurred to intellectual effort, keeps it open to new impressions, and feeds it with a constantly widening range of accurate and significant information, the specific place of race attitudes in the curriculum of the school would be of no great importance. Attitudes of curiosity and intelligent appreciation for likenesses and differences would grow of themselves. The school would create predispositions toward facing the facts of life which conservatives and radicals in the controversies around race relations would both recognize as desirable: openmindedness, sensitiveness to the demands of justice, desire for knowledge and understanding, appreciation for cultural values that are universally cherished."

In the hands of a resourceful teacher, the ordinary subjects of classroom discussion can be so handled as to provide stimulus to that kind of personality growth. Discussions of race attitudes take their place naturally in relation to other matters. In the hands of an incompetent teacher, no "fool-proof" instructions can do any good. Resistance to the mind-stunting stereotypes of beliefs about race which are so current everywhere can best be built up, as is resistance to physical disease, by the most vigorous mental health.

The spirit of the book is the spirit of modern times at its best, adaptable to rapidly changing conditions, willing to face facts and to deal with conflicts, not by suppressing them, but by freeing them to larger understanding, clear sighted in the belief that, after all, any result achieved in the elimination of friction in the social fabric is worthless unless it is the expression of freer personalities in all the groups whose interests conflict, no matter which group happens to be dominant at the time. All this, if it is in promise in these our times, is far from realization. *Race Attitudes in Children,* with its feet on the ground of to-day, reaches on into the illimitable future.

Bertha C. Reynolds.

Smith College School for Social Work.

The Dean in the High School; A Record of Experience and Experiment in Secondary Schools. By Mary Hooker Johnson. New York: Professional and Technical Press, 1929. 366 p.

The subtitle of this book, *A Record of Experience and Experiment in Secondary Schools,* well indicates the character of its contents. "The book is intended for school administrators seeking information about the scope of the dean's work, for teachers interested in the

social aspects of education, and for social workers having contact with the schools. It may also serve as a textbook in courses for the training of deans and as a supplementary textbook in classes in school administration, educational and vocational guidance, educational measurements, psychology, mental hygiene, character education, and extra-curricular activities."

The book is a description of the practices and methods used by the deans of the Washington Irving High School of New York City over a long period of years, together with some account of and comment upon usages of deans in other secondary schools. The need for the high-school dean, her position, and her activities receive initial attention. Educational guidance, health and personal hygiene, disciplinary problems, student government as a method of character training, methods of character education, and training through extra-curricular activities are the chief matters discussed.

Miss Johnson is perhaps overconscientiously thorough in the presentation of her material and has produced a veritable Baedeker of the territory she encompasses. She refrains for the most part from comment and criticism and confines herself to description of methods that she has practised and that she believes to be effective. "Cases" are cited in abundance; illustrative episodes, student organizations, and all the social phases of student activities are described in minute detail. While she emphasizes the importance of group methods of influencing conduct, the author is thoroughly in sympathy with modern psychiatric methods of study of the individual; this she refers to as "the scientific method". Illustrative paragraph headings are: "The Value of the Scientific Method"; "The Objective Attitude"; "The Relation of the School to the Mental Health of the Child"; "The Application of Psychiatry to High School Problems"; "The Deans' Need of Social Welfare Agencies".

In addition to being an excellent textbook for teachers who wish to be deans, the book may well be read by members of mental-health units functioning in school systems, as well as by social workers who have occasion to deal with schools. One gets a very concrete picture of the dean at her job, and may profit thereby in working with her. Teachers blessed with some degree of imagination and originality will doubtless find the book rather encumbered with detail, but they will be helped to an understanding of the aims, purposes, and methods of mental-hygiene programs in school systems. A fairly comprehensive selected reading list is appended.

GEORGE J. MOHR

Chicago

STUDENT PERSONNEL WORK AT NORTHWESTERN UNIVERSITY. By Esther McD. Lloyd-Jones. New York: Harper and Brothers, 1929. 253 p.

This book, according to the publishers' announcement, presents a complete and analytical description of the personnel work at Northwestern University. It reports the methods used, the results accomplished, and the lines of procedure indicated by six years' experience.

According to Walter Dill Scott, who contributes the foreword to the book, the aim of personnel work is the systematic consideration of the individual for the sake of the individual. In both educational and industrial personnel work, the preliminary activity must be to act as a coördinating agent between the student or employee and the various departments that constitute the educational institution or business organization. With the vastly increasing degree of specialization inherent in modern institutions, such a function cannot fail to be of great benefit to the individual and thus, if for no other reason, personnel work can well justify its existence.

But this coördinating function is by no means the most important element of personnel work. In present-day educational institutions, with their rapidly growing bodies of students and increasing complexity of administration, some general department with liaison functions must stand for consideration of the individual as such rather than as a piece of fluctuating coinage dropped impersonally into the cogs of the organization. To keep the necessary administrative machinery as simple as possible, to impress upon the faculty and administration the necessity of viewing each student as a human individual with vastly different feelings, thoughts, and desires from any other individual—these are the main tasks of personnel work. Presidents, deans, administrative officers, and faculty members are all too pressed for time to consider the students as anything but impersonal units in the mechanized educational process. To reëmphasize the personal aspect of those units is the greatest task confronting personnel workers.

Dr. Lloyd-Jones' book is a very comprehensive guide for any college that contemplates the initiation of a comprehensive personnel program. While the necessity of such a department in any institution is more or less obvious, it should also be borne in mind that workers in this field may become highly superficial in their methods and procedures. This point is not touched upon anywhere in the book under review. Some of the causes of this superficiality, as the reviewer sees them, are as follows:

1. Personnel directors are apt to encumber themselves and their departments with so much machinery of records, forms, and routine that the forest becomes invisible for the trees.

2. The personnel department may be concerned with such a variety of activities dealing with the entire student body that it may be physically impossible to devote more than a passing thought to some of them.

3. The whole personnel field is so relatively new that only common-sense methods are productive of sound results. Thus, when the author speaks of each branch of personnel activity being under the direction of a specialist, such as a psychiatrist, vocational adviser, etc., one is apt to question the validity of the assumptions under which these specialists work and, therefore, the practical results of their labors and advice. For instance, is enough known at present of mental hygiene, psychiatry, and so forth to warrant anything more than an interested skepticism in the results obtained?

Personnel work may be of great service to education by concerning itself with research projects of sufficient magnitude, extending over a sufficient length of time, to resolve some of the fundamental problems of education into their elements. Take, for instance, the problems arising in connection with personnel counseling, orientation of students, vocational advising, and so forth. Is any one fitted to be called a specialist in this work until the immediate problems confronting the student are viewed in relation to the life history and growth of that particular individual, taken in conjunction with his particular environment? Can one advise college students as to the comparative merits of banking or advertising as careers without knowing that individual thoroughly, his secret ambitions, his subconscious urges, and his conscious desires? None of these can be determined in one or possibly in one hundred interviews with that student. On the other hand, how well can one advise as to the opportunities, satisfactions, and problems of any one of the many functional or descriptive activities of the business or professional world, without comparable and reliable information about each of those particular activities? It is seldom that one man succeeds in mastering more than one specialized division or function of the business or professional world. For a thorough understanding of the many fields of human activity, how wise must one be? Can any one individual, therefore, be of more than very superficial assistance to a student in deciding what course he shall pursue in college or in life thereafter?

The reviewer, while realizing the creditable manner in which this book portrays the workings of a comprehensive personnel organization, would like to leave one word of caution with any of the readers thereof and with any interested workers in the field. How profound and lasting are the results obtained in individual cases, how thorough

are the researches upon which the conclusions are based—in a word, how effectively does personnel work promote the all-around development of each individual student?

Clearly the older and more formal branches of education are less concerned with this last than with the imparting of subjectual information. Sound personnel work must "impress upon the college the necessity of evaluating all the influences—aside from those of the classroom—that operate upon each student, and so modify them that the effects will be desirable in terms of individuals". By this means personnel work can lay the foundation for the well-rounded development of each individual.

JOHN C. DILLER.

Yale University.

HOWS AND WHYS OF HUMAN BEHAVIOR. By George A. Dorsey. New York: Harper and Brothers, 1929. 298 p.

Truly anthropology is the science of man. And when the anthropologist brings to bear on the problems of human behavior all the manifold phases of his science, he becomes biologist, physiologist, psychologist, psychiatrist, and sociologist, all in one.

Dr. Dorsey has attempted to answer such questions as "Why are we born gamblers? What should every mother know? What should every newborn babe have? How do you get that way? How much of your brain do you use? Why should you control your emotions? Why do we fall for each other? Why do we fall out with each other? How does your job fit you? Why do you sleep so much? Why do words boss you? What do you read? What is your royal road to learning? What is wrong with your mind? How can we be happy though married? Why aren't we the happiest people in the world?"

What can the reviewer say of such a book? Frankly, he knows not where to begin.

Hows and Whys of Human Behavior is a sort of sequel to Dorsey's *Why We Behave Like Human Beings*, an attempt to answer the questions in many thousands of letters received since publication of the latter book. In fairness to the author, one must not overlook his preface, in which he admits that the solutions of the problems discussed "are not to be thought of as final or complete—or as entirely satisfactory to the author".

With the exception of his theory of sleep and dreams, which is in sharp contrast to the Freudian hypothesis, but which still leaves one without any clear explanation of determinism in relation to dream material, the author has contributed nothing new or original.

His purpose has been rather to acquaint the lay reader with scientific explanations of everyday occurrences among human beings and to suggest means for an increase in individual happiness and efficiency.

It is difficult to take issue with the statements made and the theories advanced, since for the most part the author has kept clear of matters of a controversial nature. However, one must read a good deal that is trite, some that is utopian. For example, we have the following rules for self-advancement:

1. "Learn more."
2. "Survey the situation in which you find yourself."
3. "Inventory yourself."
4. "Stop fussing."
5. "Don't be afraid to try."

Again, the reader is enjoined to enlist the aid of the virtues: "Fear may enable you to beat a bull to a fence, and hatred to build a spite fence, but love—of home, of wife, of children, of fellow men, of fair play, of decency, of honor, of adventure, of victory, of country, of immortality—leads to real achievement." True, true, but to quote the author's own words, just "how do you get that way?" And finally: "You must be your own psychoanalyst. There is nothing mysterious about it; it is easy, you can do it." "You can remold yourself to your heart's desire." "Where there's a will there's a way." "If at first you don't succeed, try, try again." "What do you read?" In this chapter, whose title seemed to promise the key to understanding, yet another disappointment awaited. After a 15-page discussion of the difference between thinking, saying, and doing things, the author concludes: "You should yourself be the best judge of what you ought to read." "You can get an education from reading."

Dr. Dorsey's book renders its greatest service in upsetting the many popular fallacies regarding the so-called inheritance of character, personality, and genius. The newborn babe is credited with three native endowments—viz., certain bodily conformations, certain glandular mechanisms, and a capacity for learning. All else is acquired, all else explained on the basis of learning, habit, and conditioned reflex. The author, like J. B. Watson, has little use for the instincts, but he speaks freely of drives, reflexes, and impulses. He warns parents against the tendency to shape their children's lives after their own. "As the twig is bent, so is the tree inclined", but, "The world into which children were born kept changing while the children were still bent in the same old way." These chapters are forcefully and convincingly written. They place the responsibility for behavior

where it belongs—on the environment, but most of all on the parents.

Dr. Dorsey has attempted to answer in 298 pages questions on sixteen widely different phases of human relations. In this he has set for himself an impossible task. Nevertheless, the reviewer feels that the task might have been easier had he taken into account unconscious motivation.

H. N. Kerns.

New York City.

The Case of Miss R.; The Interpretation of a Life Story. By Alfred Adler. Translated by Eleanore and Friedrich Jensen, M.D. New York: Greenberg Publisher, 1929. 306 p.

Here is a very clear description of the Adlerian therapeutic technique, also an excellent example of how far one may go in an attempt to make all the symptoms of a neurosis fit one underlying motive—the will to power.

The author discusses, bit by bit, a portion of the autobiography of a neurotic girl whom he has never seen, and draws therefrom conclusions as to her "style of life" and the mechanism of her neurosis.

The life narrative is followed in the biographer's own words, keeping in mind always the patient's attitude toward life's three important issues—viz., love, work, and interhuman relationships. The youngest and pampered daughter of poor and unmarried parents, the way is early prepared for the development of her neurosis which, according to Adler, rests entirely upon an unreasonable struggle for absolute superiority. One sees early the attempt to withdraw from all situations in which the patient feels unable to make a favorable showing, eventually placing the neurosis—a severe form of compulsive actions—squarely between herself and reality.

The autobiography begins with the words, "I remember that father frequently asked me" and from this meager statement the author concludes that:

"1. The patient is more attached to the father than to the mother.

"2. The father is a soft, weak, tender-hearted man.

"3. Patient is either an only child grown up among unfavorable circumstances, an only girl among boys, or a youngest child, and that some of her organs may be deficient in functioning."

These are truly remarkable assumptions and hard to justify on the basis of so brief a statement. Obviously they are drawn from the remaining portions of the biography, but clearly no such inference is intended. The sex life, except as it indicates the lust for power, receives scant attention and in this connection sharp issue is taken

with the Freudian concepts. Sex instruction in childhood, one reads, is quite useless. Indeed, the author believes that the first information on sex should come from childhood companions; it is "gentler", for one may reject that which is too shocking, while such information coming from adults the child is forced to accept.

The patient mentions only two or three dreams, interpretation of which in the absence of associative material is merely hinted at: "The dream is an obvious fiction in which a person arranges in advance attempts and tests for controlling a future situation or solving a future problem."

In the preface, the translator has included a clear and concise statement of Adler's theory of the neuroses.

The author's conclusions from this autobiography are, on the whole, presented rather convincingly, though in some instances his efforts are a bit strained to force all the material into a single formula. Whatever the reader's psychoanalytic leanings, the book cannot fail to give him a clear account of Adler's views and his technique.

H. N. Kerns.

New York City.

Training Schools for Delinquent Girls. By Margaret Reeves. New York: Russell Sage Foundation, 1929. 455 p.

Miss Reeves has written a notable book on a subject that much needs the illumination of a careful, objective study. It is a real achievement to utter words of wisdom without betraying an undue consciousness of their weight—to analyze and to interpret simply, understandingly, and convincingly.

This is the most comprehensive and complete study of training schools for delinquent girls that has ever been made. It is not only comprehensive, but it has been written in a genuinely sympathetic spirit. The judicious attitude of the author, which strikes one forcibly throughout the volume, is evidenced in the fact that all the findings in all of the fifty-seven schools visited have been carefully weighed before the conclusions and recommendations have been drawn.

The book is so well written that it clothes with interest even the least arresting topics. Life in a training school for delinquent girls has many monotonous moments both for the girls and for the officers, but Miss Reeves's interest never flags, nor does her reader's.

The book should appeal to a large and varied audience—governors who appoint commissions and boards of trustees, the members of these bodies, superintendents of institutions, their staffs, and that wider public in whom ripples of interest sometimes disturb the generally placid calm of indifference.

One of the notable things about the book is that Miss Reeves does not describe her findings and then leave you to flounder about drawing your own conclusions. She states hers fairly, with her reasons. This helps you to crystallize your own, whether they agree with hers or not; and if they do not, hers challenge you to think out why!

If proof of the comprehensiveness of the study were needed, it can be found in the table of contents. Miss Reeves has divided her study into four parts: I. *The Institution;* II. *The Girl: Her Physical and Psychological Care;* III. *Her Education and Training;* and IV. *Community Aspects of Her Care and Parole.*

In Part I, after drawing the historical background, she turns to systems of control, with such sensible suggestions as to methods of procedure as should appeal to any group interested in the establishment of such an institution. She urges first the determination of the purpose and function of the institution planned, and stresses the importance of selecting the superintendent before deciding upon the location, the buildings, and the equipment of the plant. Appointment to a commission or a board does not carry with it a Heaven-sent gift of knowledge of the field to be entered, and Miss Reeves offers suggestions that point the way toward enlightenment.

Under such chapter headings as *The Staff, Salaries in Training Schools for Delinquent Girls, Location of Plant, Buildings and Equipment, Current Expenses and Records,* Miss Reeves not only reviews the establishment and present practices of administration in the institutions studied, but draws certain conclusions which should be carefully considered when new schools or reorganizations of old ones are contemplated.

In Part II, what these girls need in the way of physical and psychological care is discussed with great detail. What is now being done in the various training schools and the needs not yet covered fill the next chapters, whose headings indicate the importance of the discussion: *General Medical Service, Social Hygiene, Maternity Service and the Provision for Babies, Physical Care of Girls, Psychological and Psychiatric Service,* and *Social Case-work.*

The wide divergence of methods practiced in the various schools reveals a manifest need that all those interested in these institutions should reconsider their present procedures, with a view to checking up on their efficiency. That all-round studies are essential to a complete understanding of the needs of the individual girl is now acknowledged by all those familiar with the study of behavior problems in children. "This means an individualized study by physician, psychologist, psychiatrist, and social worker. Each of these specialists will think of delinquency as something caused and will try to determine the underlying factors", Miss Reeves states.

Under *Her Education and Training,* which constitutes Part III of the book, academic and æsthetic education, pre-vocational and vocational training, recreation, moral and religious training, and discipline, constructive and corrective, are thoroughly gone into.

Such questions as academic departments within the schools as against the use of public schools, if there are any within reasonable distance, the policy of vocational or pre-vocational training as a major function of these institutions, the place of recreation in the reconstruction of the girl, the importance of her religious education, and the significance of discipline as a part of her training are exhaustively, but never exhaustingly, treated.

In the final part of the book Miss Reeves has done some of her best work. She has discussed the various methods of securing community contacts for the girl both before and after her parole with thorough knowledge and sympathetic understanding of the inherent difficulties of the situation.

Statistical material throughout the book is not only abundant, but has been handled in such a way as to make possible helpful comparisons between various systems of administration. The appendices supply still further material for this purpose.

The book should be widely read. No one who has given it the careful reading it merits could fail to feel the thrill of interest it inspires in the possibilities of effective work with delinquent girls.

Edith N. Burleigh.
Child Guidance Clinic of Los Angeles and Pasadena.

Factors in the Sex Life of Twenty-Two Hundred Women. By Katharine Bement Davis. (Publications of the Bureau of Social Hygiene.) New York: Harper and Brothers, 1929. 430 p.

This book is accurately described by its title. It is not a discussion of the sex life of women in general, but an elaborate statistical report, with many tables of data and many correlations between the various sets of data. The author's comments are comparatively few, and are largely in the nature of warnings against assuming too much from the statistics, or suggestions as to the direction in which further research may be advantageously carried on. The conclusions that she herself reaches from the data are wisely cautious.

The book is the final result of a questionnaire sent out by the author under the auspices of the Bureau of Social Hygiene and a coöperating committee of representatives of important health and social organizations. An attempt was made to discover as fully as possible what the sex life of physically and socially normal, educated women is. In the book replies are used from 1,000 married women and from 1,200 single women college graduates.

The author disposes of the matter of the reliability of the questionnaire method in the last chapter, Appendix II, which consists of a report by Ruth Pointer of a comparison of this method with the combined questionnaire-interview method. The latter method was used in 50 cases by Dr. Elizabeth McCall as a part of this study. Two quotations sum up the author's opinion, and most readers will be inclined to agree with her. She quotes Peck and Wells as follows: "The objective answers can be taken not far off their face value, but the subjective answers must be taken with more reservation." Miss Pointer is quoted as follows: "The Hamiltonian method of investigation, which combines the questionnaire, personal interview, and psychoanalytical method, appears to give promise of being a more reliable method of sex investigation than the ordinary personal interview method or the sex questionnaire." The reviewer believes that, within the limits of the questionnaire method, the findings as reported in this book may be considered as reliable as is ever the case, since the group chosen was a homogeneous one of educated women, protected by anonymity, and since the questions were carefully chosen and worded, and allowed of little ambiguity in replies. Furthermore, the data at hand have been most skilfully used by a clear-headed person who has known how to arrange her material in such a way as to let it tell its own true story.

Two chapters of the book (I and V) give the background of the two groups studied. Many correlations are made in the other chapters between the facts presented in them regarding the sex life and the basal facts regarding the women in respect to such matters as age, health, education, occupation, recreation, interests outside the home, pregnancies, number of children, age at marriage, residence in early life, and so forth. An attempt has also been made to classify the women in respect to mental health, adaptation in life, and satisfaction with life. The term "nervous breakdown" has been used as the gauge of mental ill health. Strangely enough, this particular question seems to have been asked only of the single women, of whom nearly 20 per cent had had what they called breakdowns and nearly 10 per cent had been near to it.

Chapters II, III, and IV deal with married life, and were first published in the *Journal of Social Hygiene* between 1922 and 1925. Chapter II presents statistics regarding the use of contraceptives and correlates that information with various other factors. We learn that contraceptives were used by 73 per cent of the married women, largely for economic or health reasons, and that only 7.8 per cent of these 1,000 women disapproved of contraception. Yet the group that used them had a higher rate of pregnancy and more children than those who did not. Only 7.1 per cent of the 1,000 women had intercourse

before marriage, but the percentage is three times as high among those who had information about birth control as among those who did not. Of the 1,000 married women, 9.3 per cent had had abortions, to the number of 147. A section of this chapter is devoted to an attempt to correlate frequency of intercourse with sterility, a study made at the suggestion of a prominent gynecologist. The facts seem to show a negative rather than a positive correlation, since 100 per cent of those who had intercourse oftener than daily became pregnant, although more in this group than in any other used contraceptives.

Chapters III and IV deal with happiness in married life. The replies to the questions asked were given in sufficient detail to make these chapters interesting. Chapter IV deals particularly with the sex factors in marriage, as they make for happiness or the reverse. The most notable positive correlation is between instruction prior to marriage regarding marriage relations and the subsequent pleasurableness of these relations, and between continued agreeable sex relations and general happiness in marriage.

Chapters VI and VII appeared in MENTAL HYGIENE in 1924 and 1925. They deal with auto-erotic practices in women. Such practices were admitted at the time of answering the questionnaire by 31 per cent of the unmarried women, and denied in either the present or the past by an equal per cent. Twenty-nine per cent admitted them in the past, and 7 per cent failed to answer the questions. Correlations are made of this practice with numerous other factors, and the statistics are compared with statistics published on auto-erotism in men. Tables show the frequency of the various means by which the habit was acquired, the experience of orgasm, reasons for the practice, reasons for stopping it, and the various mental attitudes toward it. It is interesting to note that 34 per cent of those at the time practicing masturbation believed it to be harmful to them. In presenting the facts regarding auto-erotic practices in married women, there is a section on the relation of masturbation to the reaction to marital relations. Dr. Davis sums up the discussion by saying: "It is quite probable that masturbation may be a symptom of a type of personality rather than in itself a causative factor."

Chapters VIII and IX were first published in 1926 and 1927 in the *American Journal of Obstetrics and Gynecology*. They deal with sex desire in the unmarried and the married. The two groups are compared. It seems a little surprising that more than 10 per cent of the unmarried consistently deny any sex impulses, and by their replies to various questions seem to confirm their assertion. An interesting finding is that periodicity of sex desire is very much less often reported among those of the homosexual trend than among the autoerotic or the heterosexual.

Chapters X and XI deal with homosexuality in both groups. These chapters have not previously been published. Among the unmarried women 50 per cent have had intense emotional relations with other women, more than half of these recognized at the time as sexual and for the most part accompanied by physical expression beyond hugging and kissing. The college period appears to be the most frequent time of such affairs, although the more definitely sexual experiences seem to increase after college. It is interesting that only a few of those who were homosexual feel that their tendency had an influence in keeping them single. It is also interesting that the rate of "nervous breakdowns" was about the same in the homosexuals whether there was much expression of emotion or not, and that in both the rate was higher than in those who deny any special emotional relations to other women.

The twelfth chapter is by Ruth Topping, and consists of an interesting series of correlations between opinions held by these women and their practices. Attitudes toward the necessity for sex intercourse, its occurrence outside marriage in both men and women, prostitution, and sex education are treated in tabular form. In this section many quotations are made from the replies, which give color to the opinions expressed.

The first appendix tells of the replies to follow-up letters sent out in an effort to find out why a large number of women who had agreed to fill out the questionnaire failed to do so. Naturally a considerable proportion gave the rationalized excuse of lack of time; only 5.7 per cent criticized the questionnaire.

There is a wealth of material in this volume, and it is presented in a way that is easy to grasp. To round out the subject, it would seem to the reviewer that it would have been desirable to have two chapters dealing with heterosexual relationships outside marriage as fully as the two chapters each on marriage relations, auto-erotic practices, and homosexuality cover these subjects. The statistics on this field are relatively meager.

The author and her assistants deserve much credit for the way in which they have carried out this study, which cannot fail to be interesting and valuable to those who are in any professional way called upon to consider the sex life of girls and women.

Boston. FLORENCE MEREDITH.

LIVING WITH OUR CHILDREN. By Lillian M. Gilbreth. New York: W. W. Norton and Company, 1928. 309 p.

If personal experience enables one to understand similar experiences in others, certainly this author is well qualified to execute the task she has undertaken here. Her book makes one feel that, having studied

the problem in her own relationship to the family that she knew best, she appreciates the value of truly living with our children.

She clearly recognizes the individuality of every member of the family, but more significant is her realization that each family unit presents its own problem. Therefore, she lays down no hard-and-fast rules of conduct, but rather stresses the importance of the feeling tone of the two persons on whom this family unit will depend.

She rightly bases the success or failure of children upon the attitude of the parents toward each other. If this is sound, then the effort to understand the children becomes an attractive game of life.

The book is divided into three parts, each of which discusses one of the three important components of living—planning, performing, and evaluating. In the first part, the author takes up the value of making a plan, of the importance for a man and a woman who marry of surveying their potentialities, which have been handed down from their ancestors, and their background, and of endeavoring to understand the plan set forth. The next section, that of performing, carries one in detail through the daily problems of life. Mrs. Gilbreth sees that the events of daily existence are not so important as the emotions that accompany them. For example, on page 196 she says, "Then if a child is made to realize that at certain times and places he must be quiet because his father and sister are nervous or ill, the effect on him will not be as harmful as it is when he is taught that noise and running about are wrong in themselves." In short, the affectivity toward mental content, and not the content, is the crux of one's adjustment. A sensible philosophy is set forth in the third section. In evaluating one's projects, her test of success is whether "they have contributed to the achievement of our aim to make each member of the family an adequate individual".

The reviewer cannot recall a situation likely to occur in family life that has not been touched upon or mentioned in this book. Although there are many useful bits of advice and innumerable adages that might well be remembered, the author has not theorized, but rather analyzed the family situation and laid down therapeutic rules of thinking and conduct. Her reason for writing this book is that "we are all such a tangle of emotion, impulses, urges, and desires that any training which enables us to grasp a few underlying and stabilizing principles is of incalculable value". There are a few minor pieces of advice with which one may not wholly agree. For example, on page 189 we find the statement, "Never spare praise of his successes." Just how much praise to give a child is a moot question.

To follow the author's plan, a man and woman must be adequate and hence capable of loving. To those who are not, the book will be

of little value. But those who are desirous of influencing human motivation can glean many helpful suggestions from it. The style is simple and direct, which makes it easily readable.

ELIZABETH I. ADAMSON.

Vanderbilt Clinic, New York City.

THE KINGDOM OF THE MIND. By June E. Downey. (The Young People's Shelf of Science series.) New York: The Macmillan Company, 1927. 207 p.

In accordance with the aim of the Young People's Shelf of Science, as expressed in the editor's introduction, the author very successfully attempts to present some of the more interesting facts of general psychology in an attractive, readable form. The scope of the subject matter is surprisingly wide, when one considers the limitations necessarily involved in such a task; for, extensive as is the field from which the selection is made—namely, the whole realm of mental science—the immature nature of the reader for whom the book is primarily intended demands an abnormal amount of care and insight on the part of the author in choosing and presenting the most suitable facts. To include material from the realms of sensation and perception, memory, imagery, illusion, learning, self-testing, character reading, and character development—all of which is not only fascinating, but also arranged in excellent sequence—is a feat deserving of deep admiration. And with the exception of her treatment of imagery, the author has in the main avoided all topics likely to confuse the reader, such as those around which most of the subtle arguments of modern controversies revolve.

The factual material is amply supplemented by pictorial, verbal, experimental, and diagrammatic illustrations. These are clear, well chosen, and in keeping with the penetrating, yet delightfully interesting, nature of the whole work. The language is simple and in the main well adapted to its purpose. Perhaps, however, the author has occasionally employed terms that are too childish for those who are sufficiently developed to be able to appreciate the contents; and not infrequently she has fallen into the error of confusing questionable phrases and sentence forms with simplicity of diction.

To all students of psychology, the book will make an undoubted appeal, despite the above minor limitations. Any adult would profit by reading it, and at the same time would derive an enormous amount of enjoyment from so doing; while the popular lecturer on psychology will find the work an invaluable aid in selecting illustrative material. Whether the subtle nature of the science will militate against the success of 'teen-age youths in applying the rules so skilfully presented is perhaps an open question. But at least an interest in the elements

of applied psychology will be aroused, and such a result would be, in itself, the highest tribute the author could receive. Immature applications of a highly specialized science are not merely undesirable; they may be distinctly harmful—to the individual as well as to the science—and perhaps psychology has suffered more than it has deserved for this tendency. But such criticism is not entirely germane to the present case, since *The Kingdom of the Mind* is mainly concerned with awakening the interest of the growing boy or girl (and of the public generally) in some of the most enthralling aspects of mental health and efficiency.

W. Line.

Mount Allison University.

Two Souls in One Body. By Henry H. Goddard. New York: Dodd, Mead, and Company, 1927. 239 p.

This is a study of an adolescent girl who presented the picture of a major hysterical reaction. As Dr. Goddard mentions, many cases of dual personality (some real, some fictitious) have been described and studied. His object in writing this book is to promote a keener appreciation of the necessity for understanding children and to do away with the belief that occultism and mysticism may be causative factors in mental disease and deviations in human behavior.

Any consideration of this girl's personality, as in all those who exhibit hysterical mechanisms, could be approached from various points of view. The physical components of the disturbance might be accounted for by organic neurological abnormalities, or the faulty reaction pattern might be ascribed to a conscious volitional process, thereby drawing it nearer to simulation. The author evidently realizes that neither of these approaches would answer his question. He, therefore, considers this personality as one who biologically had a lowered nervous threshold for both internal and external stimuli and in her psychological setting succumbed. On page 108, he says, "The one fundamental condition upon which dual or multiple personality is based is a more or less exhausted or weakened nervous system—a nervous system that does not develop its full quota of energy." And yet he recognizes the unhealthy background of the girl, and his therapy is applied accordingly.

For the laity the book is of interest because it annihilates the superstition that demoniacal possession is the cause of hysteria. To the physicians who see only the pathology of an organ or system as the etiology of odd behavior, the book will be of value because the author demonstrates that in such an illness the entire organism must be reckoned with and treated. To us who deal with personality deviations and who, at times, believe that mental hygiene is making great

strides, the book will be discouraging in the matter of the correspondence that came to Dr. Goddard from "all sorts and conditions of men" offering therapeutic suggestions. Such letters clearly show that the unseen and the obscure facts of life are not dealt with from the psychiatric approach by the average person.

The contents of the book are given at a somewhat descriptive level; nevertheless, genetic and dynamic considerations are not lacking. It is very readable because of the simplicity of its style and structure.

Vanderbilt Clinic, New York City. ELIZABETH I. ADAMSON.

THE PROCESS OF HUMAN BEHAVIOR. By Mandel Sherman, M.D., and Irene Case Sherman. New York: W. W. Norton and Company, 1929. 227 p.

In the introduction to this volume, we read: "This book does not attempt to present an exhaustive study of its subject. Its aim is rather to outline the principles underlying the processes of human behavior and the important factors which influence it; to describe the working of the human organism as a whole, and the genesis and development of the methods by which adjustments of the individual to his environment are affected." This, indeed, would be a praiseworthy undertaking, and more so if it could be accomplished in the space of 219 pages.

The book has eight chapters. The first two, which are on the nervous system, and much of which, as the Preface states, have "been borrowed from other authors", prepare the ground for Chapter III, *The First Human Responses.* The following quotation from the opening paragraph of this chapter will give the authors' point of view and the nature of the treatment of material subsequently followed: "The first overt bodily reactions of the newborn infant are simple sensori-motor responses which are strikingly undefined, uncoördinated, and aimless. With the increase in age and experience, these reactions of the bodily musculature become guided and usefully coördinated, indicating that most of the complex behavior of the growing infant is the result of a direct learning activity rather than the manifestation of inherited modes of response. Out of the vague, undifferentiated behavior of the infant are built up the characteristically adaptive responses seen later in life."

Chapter IV continues the same line of thought in discussing the development of intelligence. Here we read: "The first signs of intelligence in the newborn infant are manifested in sensori-motor responses, and the development of intelligence is directly related to the development of these reactions." Further on in this chapter we are told: "Recent experiments . . . have shown that in-

dividuals who have good intelligence according to the usual criteria do better in tests of mechanical ability than mentally defective individuals.'' And then the authors assume even more in their attempt to fit into their system this: ''Freeman showed that foster children placed in an improved environment make a significant gain in intelligence. Those placed in better homes gain considerably more than those in poorer homes. Also those who are adopted at an early age gain more than those adopted at a later age, showing that an improved environment and better training are most effective in influencing intelligence during the early plastic period of the child's life.'' It must be remembered that the authors make development of intelligence dependent solely on sensori-motor activity. Language, according to their view, ''is a symbolic replacement and continuation of the early sensori-motor responses''.

Chapter V deals with observations of the emotions. The authors state: ''Every one is liable to error in judging the emotional expressions of infants.'' The authors do not believe ''that the emotions are native characteristics with a predetermined pattern'', for they assert, ''It is only after the child begins to have knowledge of the social significance of his behavior that any of his responses can be named as definitely emotional.'' Again, in Chapter VI, *The Nature of the Emotions and Their Influence upon Behavior,* we are told: ''What we call the emotions, therefore, are not present in the infant at birth, but develop, as a result of experience, as specific patterns of response. . . . But this development begins immediately after birth with the handling of the child, who eventually learns to respond with specific emotional reactions because of the training he receives.''

In regard to the genesis of specific emotional responses, we are told that ''very early two types of adjustive reaction can be noted: first, that of *rejecting* a stimulus, and, second, that of *accepting* a stimulus''. ''The emotional activity which serves to reject a stimulus may be divided further into two types: (1) rejection by retreat; (2) rejection by aggressive activity.'' And further on: ''When a child makes an aggressive reaction toward an object, his behavior is labeled anger and comes to signify anger to him. When he retreats from a situation, his behavior is labeled fear and comes to signify fear to him. He is told by his parents not to get angry (show aggressive behavior), or not to be frightened (show retiring behavior), and thus he comes to establish an attitude toward each type of response. He soon learns that aggressive behavior typifies anger and that retiring behavior typifies fear. In other words, particular emotional responses develop out of his learning the significance of types of behavior which are then characterized as emotions.''

Chapter VII, *The Development of Personality,* opens with this enlightening(?) definition: "Personality is the characteristic behavior of an individual." In their discussion of the relation of sensori-motor responses and intelligence to personality, the authors state: "If the sensori-motor responses are sluggish, for instance, the personality may be characterized by a sluggish response under most conditions, and if they are quick, the individual is likely to be an active, impulsive type."

In Chapter VIII, *Personality and Social Behavior,* the authors discuss personality types. They chide other authors for theorizing about constitutional personality types: "Thus they classify personalities into the athletic and other types on the assumption that personality traits are inherently determined by structure. One can readily see, however, that these types are not due to innate predispositions, but to the physical, metabolic, and nutritional condition, and to sensitivity and speed of reactivity."

The book as a whole is unsatisfying. Its psychology is a thoroughgoing behaviorism. The explanation of the whole of human behavior in all its forms of expression is reduced to sensori-motor activity. This makes the chapters on emotion and personality very unsatisfactory. The book furthermore assumes much. It will be annoying to the scientific mind.

Cleveland Child Guidance Clinic. HENRY C. SCHUMACHER.

SCHIZOPHRENIA (DEMENTIA PRAECOX); AN INVESTIGATION OF THE MOST RECENT ADVANCES. The Association for Research in Nervous and Mental Diseases. (Series of Research Publications, Vol. 5.) New York: Paul B. Hoeber, 1928. 491 p.

This book is one of the most valuable publications thus far issued by the Association for Research in Nervous and Mental Diseases, and the discussion of schizophrenia at this time is very opportune. The material presented is divided into nine sections, consisting of a historical survey; statistics regarding the frequency of schizophrenia in relation to sex, age, environment, race, and heredity; etiology; investigative aspects; language and art productions; pathology; prognosis; and treatment.

It is appropriate that the first paper, which concerns the evolution of the dementia-praecox concept, should be by Adolf Meyer. Meyer aptly tells us that "the history of dementia praecox is really that of psychiatry as a whole". He begins the survey with Pinel, of the early French school, and traces the evolution of our conceptions of dementia praecox by emphasizing the individual contributions of

Morel, Zeller, Griesinger, Kahlbaum, and Kraepelin to the present-day Meyerian school of the dynamic genetic type. In this section Campbell defines the schizophrenic type of reaction, and Brill discusses schizoid and syntonic conceptions.

Section II, by Pollock, gives us valuable statistical material based on a study of 17,722 first admissions to the New York state hospitals. He concludes from this material that schizophrenia has an earlier onset and is more prevalent among males, in cities, and among the foreign born.

Section III, by Barrett, indicates that hereditary tainting factors are found to be present in 78.01 per cent of schizophrenic patients. Myerson concludes that a biological connection between schizophrenia and feeblemindedness is unlikely. Raphael, in his studies of the constitutional factors, indicates the validity of Kretschmer's conclusions regarding the frequency of asthenic and dysplastic body types in schizophrenia. In a study of 60 cases the asthenic body type was found in 13.3 per cent, the dysplastic in 10 per cent, mixed and unclassified types in 56 per cent, pyknic in 5 per cent, and athletic in 15 per cent. Amsden discusses the personality types found in schizophrenia.

Section IV gives special etiological considerations subdivided into affective experiences (Sullivan), psychogenic precipitating causes (Hutchings, Cheney, Wright), schizophrenic manifestations in prisoners (Adler), relation between alcoholism and schizophrenia (Gregory), acute infectious diseases (Menninger), and the mental pictures of schizophrenia and epidemic meningitis (Jelliffe). This section is very interesting, but somewhat disappointing in that there is considerable scattering and a lack of definiteness in the material presented.

Section V deals with the investigative aspects of this disease and consists of five papers. The psychogalvanic studies reported by Syz are of interest here as well as the studies of gastrointestinal motor functions reported by Henry. We see again in this section the need for continued work on this disease.

Section VI, language and art productions in schizophrenia, gives us two very interesting papers which indicate the advances that have been made in interpretative psychiatry. The language of schizophrenia is discussed by White, and graphic art productions, beautifully illustrated, by Lewis.

The section on pathology is very concise, and one feels that we can definitely agree with Dr. Dunlap that the changes in the brain of schizophrenia "are not only inconstant and non-specific, but they are such as may be found in any series of control cases; in other

words, their significance for the disease process seems to be without importance''. Freeman, in his discussion of lipoid degeneration products, indicates a similar non-specificity. He finds well-defined lipoid degeneration products in the basal ganglia of schizophrenic patients, but considers these non-specific. Lewis indicates that changes in the endocrine organs in schizophrenia are the result of intercurrent and chronic diseases, especially tuberculosis, and that these lesions cannot be considered specific for schizophrenia.

Section VIII consists of an interesting paper on prognosis by Strecker and Willey. A group of 186 patients were studied, of whom 38 were considered as ''recovered'' on the basis of follow-up studies of approximately five years' duration. Of these 38 cases, 18 were catatonic, 8 hebephrenic, and 12 paranoid. The prognostic indications were studied from the points of view of race, complete family and personal history, personality, pre-psychotic somatic status, precipitating situation, and physical phenomena of the psychosis. The discussions in this section are extensive and indicate the wisdom of a more optimistic prognosis in schizophrenia, especially if our patients are completely studied.

In Section IX, Hamilton reviews modern conceptions of treatment. He wisely begins by stressing the importance of early preventive treatment during childhood. Discussing the measures that comprise our armamentarium for combating schizophenia, he takes up the physician's attitude toward the patient; the treatment of negativistic states and stupor, excitement, apathy; medicinal and surgical procedures; psychotherapy; and social treatment. The material in this section is well organized. The discussions at the end of each section add to the interest and clarity of each presentation.

We heartily endorse this book from every point of view, and hope that it will stimulate additional studies which will throw light on our dementia-praecox problem.

Dr. Franklin G. Ebaugh.

Colorado Psychopathic Hospital.

Our Minds and Our Motives. By Paul D. Hugon. New York: G. P. Putnam's Sons, 1928. 475 p.

Mr. Hugon has set for himself the substantial task of defining nearly five hundred pages of terms current in psychology, theosophy, psychoanalysis, and popular psychological literature. His definitions vary in length from two or three lines to the six or seven pages he devotes to a discussion of the origin and meaning of ''language''. He includes some praiseworthy practical discussion, such as his treatment of the ''scientific method'' and ''evolution''. On the other

hand, a great many otherwise commendable articles in this compendium are spoiled by the introduction of obsolete and archaic notions. Reference to "faculty psychology" as an explanatory mechanism, a sentimental treatment of "marriage", an inaccurate definition of "intelligence", a wholly erroneous explanation of the "intellectual quotient" (which is also a misnomer), an unsatisfactory treatment of "feeblemindedness"—these are only a few of the features that mark this book as pseudo-scientific.

In his treatment of the emotions and their expression, Mr. Hugon sets forth Darwin's theory of the purposiveness of emotional behavior much as if this theory were accepted to-day. In discussing the facial expressions of the emotions, he remarks that a person's habitual expression is called his "countenance", and that "intelligence . . . is the coefficient of intensity which makes all other faculties greater". (Page 256.)

The author apparently believes whole-heartedly in the scientific validity of graphology. "Obstinacy expresses itself physically by a refusal to budge, and is similarly indicated in handwriting by a heavy downward movement such as strokes reaching below the line instead of going forward at the end of a word, as if the writer sought to drive a pole into the ground." (Page 332.) In his discussion of phrenology (page 349), he fails to leave the reader with any inkling of the fact that anthropometric measurements of the length and breadth of the head, the height of the forehead, the length of the nose and chin, have conclusively proved through thousands of experiments that peculiarities of the skull and facial bones bear no relationship to general intelligence and mental development. Indeed, we get an entirely opposite impression—that is, that Mr. Hugon believes that scholarly men always have lofty foreheads and large brain cavities.

The vast amount of material connected with psychopathology has been omitted from this book. Indeed, the pathological is treated only through the eyes of academic psychology. We suspect that the writer has never seen a case of dementia praecox or manic-depressive psychosis, neither of which are mentioned. In an inadequate discussion of "hysteria" (page 238), he defines it as "a condition of nervous exhaustion induced by strain . . . occurring particularly in men and women with a poor nervous heredity". There is no discussion of the leading theories on the etiology and symptomatology of this disease or of any other psychopathological condition glibly summarized in this volume.

If this book is valuable at all, it is for the sake of the material included on Hindu "mysticism", "palingenesis", and various theosophical cults of the Orient and Occident, of which the average reader has only the vaguest notions. It is hard to understand, however,

why some of the items have found entry. What place has "repartee", "quality", "religion", "dramatic ability", and numerous other concepts, in a book purporting to be devoted to an objective exposition of the more technical terms current in psychology?

It is impossible, however, to criticize Mr. Hugon for his sins of omission. Here are jottings from his private social philosophy and not a documented encyclopedia of psychological terms. As such the book must be judged, and many interesting observations may be gleaned from it.

Grace E. O'Brien.

New York City Committee on Mental Hygiene.

Victim and Victor. By John Rathbone Oliver, M.D. New York: The Macmillan Company, 1929. 435 p.

Dr. Oliver believes that to deal successfully with certain types of mental diseases, it is necessary to supplement the work of the psychiatrist with that of the priest. *Victim and Victor* is an attempt to dramatize this idea. Michael Mann, a priest whose understanding of the mental processes of other troubled minds grows out of his own abnormality, is the central figure of the novel. Coöperating closely with him, but subordinate to him in resourcefulness and force of character, is Dr. Claude Monroe, the psychiatrist who tells the story.

As a layman with a very decided respect for the medical profession as a whole, it is impossible to regard without prejudice an arrangement by which the doctor takes his orders from the priest. Rarely in literature does one meet with a person so spineless and flabby, both intellectually and spiritually, as the narrator of this tale. Instead of describing an expert who is trained to penetrate the superficial actions and mannerisms that men use to cover up their real motives and who is skilled in unraveling the intricacies of human behavior, the author presents a doctor apparently not far removed in mentality from a border-line case himself. Granted that his ineptitude and ineffectualness are the result of his early conditioning, it is nevertheless difficult to conceive of any reputable psychiatrist so lacking in insight and so easily misled by every individual with whom he comes in contact. The best descriptive phrase is the one used derisively by a criminal paroled in his custody, who talks about how he first deceived the judge and then "got out on suspended sentence—on parole to a nut doctor—easier, softer than the judge. I coaxed a few dollars out him—but not enough." Such incidents and statements could be multiplied indefinitely by direct quotation from the book. Again one wonders whether in any first-rate hospital it is customary for a member of the medical staff to consult one of his patients about the other cases under treatment, to ask for advice in handling the situation that arises when

a depressed youth bent on suicide escapes from the hospital, and meekly to accept the written suggestions handed to him by a layman! This reviewer thinks such a state of affairs more than a little incredible.

Coming now to the underlying thesis of the book that medical service, in order to be effective, must take into consideration the whole individual and his composite spiritual, mental, and physical make-up, we thoroughly agree with the validity of this position. We admit that, all too often, physical factors are over-emphasized at the expense of those more intangible elements which in the long run may determine the success or failure of life. In the curing of disease, especially disease of the mind, there is sometimes room for the ministrations of both physician and priest. But the issue cannot be confused as it is here; the consolations of religion can allay mental distress in only a small minority of cases. To be of definite value, a philosophy of life that resolves the internal conflict and gives peace of mind cannot be imposed casually from without by the suggestions of even the best-beloved adviser, but must be the outgrowth of an emotional synthesis. Is it not the rôle of the doctor to help the patient understand himself and thus help him work out his own salvation? The priest seems to realize this important fact better than the doctor; but the solution of our problem is rather to give our medical students some knowledge of the motives that determine conduct, so that later on in their practice they will not have to throw up their hands in despair and rely upon outside assistance to save the day whenever they are confronted with the crises that follow serious individual maladjustment.

Aside from these fundamental weaknesses, the book is rather interesting. The first section portrays the attitude of mind with which a highly emotional, repressed, somewhat abnormal boy approaches his ordination into the priesthood, which represents to him the summit of his ambition and the goal of his desires. This part is very sympathetically written. In addition, it holds the attention of the reader. So, too, does the sketch of prison life and the other scenes preceding Michael Mann's appearance as a patient in the psychiatric ward of the hospital. From that point on the book is only intermittently entertaining. Some of the case studies, which are episodically treated, are suggestive in that they show the various ways in which people mess up their own lives, but they are not particularly original nor spectacular. Neither do they give the well-informed reader much new understanding of the motives that underlie human behavior. Therefore we think that, all in all, *Scarlet Sister Mary,* which is a consistent, convincing character sketch, was a more worthy recipient of the Pulitzer prize.

Bessie Bunzel.

New York City.

GENIUS; SOME REVALUATIONS. By Arthur C. Jacobson. New York: Greenberg Publisher, 1927. 160 p.

This book looks at genius largely from the viewpoint of chemistry and biology. One cannot but be disappointed that due consideration is not given to psychological interpretations. The author presents a vast amount of material on geniuses and their works, but when he comes to the evaluation of genius—or, to use his own term, the "revaluations"—he deals largely with speculation and scientifically unproved factors.

The chapter, *Alcohol and Art,* portrays many of the familiar associations of alcoholic indulgence and creative genius in the fields of literature, music, and painting, and also suggests some less familiar examples of ethylic relationship to genius. With this chapter we are in the main in complete sympathy.

When we reach the chapter, *Tuberculosis and the Creative Mind,* we find ourselves on very much more uncertain ground. We are loath to subscribe to the chemistry of the disease as the all-important factor, and here certainly would want to study more carefully the environmental and psychological concomitants.

The author devotes a chapter to Dr. Jeannette Marks's *Genius and Disaster,* and pays this book the highest tribute, as is very proper, because of its most incisive intuition into the mind of the genius and his productions.

The chapter called *Appraisals* gives us some interesting material of eugenic value, especially in that part that points out the unpredictability of the breeding of genius.

We regret that the obsolete medical term "insanity" is constantly used in trying to prove that mental disease and genius are incompatible. The relationship of mental-disease processes and genius are too well understood to-day to be discredited, and the author's use of the term insanity displays a lack of understanding of the modern concept of mental pathology that must inevitably lead him far afield in his deductions. We cannot but wish that the amount of work that went to produce this book could have been combined with a more modern psychopathological technique. We should then have had less speculation about the chemistry of genius and a better picture of the genius himself, his environmental factors, his psychological, as well as chemical urges, and thus a more rounded understanding of the products of genius.

ARTHUR H. RUGGLES.

Butler Hospital.

NOTES AND COMMENTS

Legislative Notes

NEW LAWS

Index by Subject

Administration and Finance
California H. 692; Colorado H. 43; Connecticut H. 208.

Delinquent, Defective, Dependent, Psychopathic, and Maladjusted Children
California S. 783; Idaho H. 168; Iowa H. 503; Massachusetts S. 53.

Examination of Persons Accused of Crime
Massachusetts S. 186.

New Institutions and Clinics
Connecticut H. 208; Delaware S. 29, S. 30, and S. 31.

Sterilization
Iowa H. 243.

Veterans
Connecticut H. 295; Iowa H. C. R. 13 and S. 33; Kansas H. 133; Maine H. 78; Michigan S. 274.

California

H. 692, Chapter 407. Amends the "Pacific Colony Act" by providing for the designation, by the judge, of "some county officer" who shall be responsible for the collection of all fees connected with the investigation, detention, and commitment of feebleminded and epileptic persons, and keep complete records of such transactions; and providing further, that in the case of every person committed to the Pacific Colony, the county from which he is committed shall pay to the state treasurer $15.00 per month for every month he remains in the colony. (This bill was erroneously listed in the April Number of Mental Hygiene as "establishing a colony for feebleminded persons".)

S. 783, Chapter 224. Provides for the retention of the Commission on Juvenile Delinquency, and requires said Commission to report to the 49th session of the legislature, the report to embody a plan for the prevention of juvenile delinquency and for the care and training of pre-delinquent, psychopathic, and maladjusted children.

Colorado

H. 43 (Same as S. 45). Assesses an annual license fee of two dollars against all resident, and of $10.00 against all non-resident, medical practitioners.

Connecticut

H. 208. Special Act 445. Provides for the establishment of the Fairfield State Hospital for the Insane, and the appropriation of $1,750,000 for same.

H. 295. Provides for the guardianship of incompetent veterans and minor children of disabled or deceased veterans, for the commitment of veterans, and for making uniform the law with reference thereto.

Delaware

S. 29. Creates a psychiatric clinic at the State Hospital for the Insane.

S. 30. Authorizes the establishment of a mental-hygiene clinic under the direction of the trustees of the State Hospital for the Insane.

S. 31. Authorizes the establishment of a psychiatric observation clinic at the State Hospital for the Insane.

Idaho

H. 168. Provides that the parents or persons having the custody of a child under the age of eighteen years, who encourage or contribute to the delinquency of such child, shall be guilty of a misdemeanor.

Iowa

H. C. R. 13. A resolution to Congress to provide for the immediate enlargement of the World War Veterans' Hospital at Knoxville. (Resolution adopted.)

H. 243. Repeals the sterilization law and substitutes for it a new law providing for the sterilization in the manner deemed most advisable (castration being excepted) of all persons, living in the state, who are feebleminded, insane, epileptic, habitual criminals, moral degenerates, or sexual perverts, or are likely to become a menace to society, if, after due examination by the State Board of Eugenics, it be decided that procreation by such persons would produce a child having an inherited tendency to such afflictions or who would probably become a social menace or ward of the state, and there is no probability that his condition will improve to such an extent as to avoid such consequences.

H. 503. Directs the superintendent of public instruction to make research study of certain features of the public-school system, and to determine the number of physically and mentally handicapped children in the state, and appropriates funds for such a survey.

S. 33. Provides for the guardianship of incompetent veterans, etc. (Same as Connecticut H. 295.)

Kansas

H. 133, Chapter 250. Provides for the guardianship of incompetent veterans, etc. (Same as Connecticut H. 295.)

Maine

H. 78. Provides for the guardianship of incompetent veterans, etc. (Same as Connecticut H. 295.)

Massachusetts

S. 53, Chapter 12R. A resolve providing for an investigation by a special unpaid commission of the laws relative to dependent, delinquent, and neglected children or other children requiring special care.

S. 186, Chapter 105. Amends the "Briggs Law", by making accessible to probation officers reports relative to the mental condition of certain persons held for trial.

Michigan

S. 274, Chapter 156. Provides for the guardianship of incompetent veterans, etc. (Same as Connecticut H. 295.)

BILLS THAT FAILED

Index by Subject

Administration and Finance
California H. 309, S. 103, S. 201; Idaho H. 115; Michigan S. J. R. 6; Minnesota S. 420.
Commitment
Iowa H. 163.
Criminal Insane
Michigan H. 109.
Delinquent, Defective, Dependent, Psychopathic and Maladjusted Children
California H. 167; Kansas H. 161.
Insanity Pleas in Criminal Cases
California H. 768; Iowa S. 340; Michigan H. J. R. 5.
Marriage and Divorce
California H. 47 and H. 346; Iowa H. 115; Michigan S. 146; Minnesota H. 783.
Miscellaneous
California S. 556; Florida H. 900; Kansas H. 57, H. 276, H. 310; Massachusetts S. 169, S. 172.
New Institutions and Clinics
Minnesota H. 818, H. 842, S. 420.
Persons Accused of Crime
California S. 201; Connecticut H. 64.
Sterilization
Colorado H. 136.
Temporary and Observational Care
Michigan H. 78.
Veterans
Florida H. 10; Minnesota H. 954.

California

H. 47. Making insanity a cause for divorce. Summarized in the April Number of MENTAL HYGIENE.

H. 167. Providing an institution for the confinement and care and rehabilitation of defective delinquents and for their admission and commitment. Summarized in the April Number of MENTAL HYGIENE.

H. 309. Providing for city and county boards of mental health.

H. 346. Requiring a health certificate before marriage showing absence of venereal disease. Pocket vetoed.

H. 768. Changing the order in which the plea of "Not guilty by reason of insanity" shall be tried.

S. 103. Creating a committee to select a site for a new insane hospital.

S. 201. Providing for the maintenance in state hospitals of persons accused of crime. Vetoed.

S. 556. Providing for the arrest, without a warrant, upon probable cause, of alleged insane persons. Vetoed.

Colorado

H. 136. Providing for the sexual sterilization of any inmate of a state institution having insane, feebleminded, or epileptic inmates if deemed advisable by the governing commission of that institution.

Connecticut

H. 64. Providing a fine of $500 or imprisonment for not more than one year for any person who shall wilfully and unlawfully cause or permit any child under sixteen to be placed in such a situation as to imperil life, limb, or morals.

Florida

H. 140. Providing for the guardianship of incompetent veterans, etc. (Same as Connecticut H. 295, summarized above.)

H. 900. Requiring the several boards of county commissioners to provide hospital wards for the sick and insane prisoners in the county jails of the state.

Idaho

H. 115. Creating a commission to investigate the operation and maintenance of the State Insane Asylum at Blackfoot and the Northern Idaho Sanitarium at Orofino with a view to consolidating the two institutions.

Iowa

H. 115. Would repeal certain sections of the laws governing divorce. Of particular interest is the proposed change in the section concerning insanity as ground for divorce. The law reads that divorces may be decreed "8. Where either party was insane or idiotic at the time of marriage." The proposed substitute reads, "8. Where either party is and has been incurably insane for a period of three years or under guardianship as an incompetent."

H. 163. Providing for a jury trial or appeal from an order committing a person charged with insanity.

S. 340. Would require any defendant in a criminal case, who intends to rely upon the defense of insanity or alibi, to serve notice thereof before the trial, and to provide for the appointment by the court of experts to examine and offer evidence at the trial of persons claiming insanity or a defense for crime.

Kansas

H. 57 (Same as S. 173, also defeated). Would provide for private hearings in all cases tried before courts of inquisition, of divorce, breach of promise, seduction, rape, crimes against public morals and decency, and all similar cases involving testimony of sexual, salacious, or suggestive character.

H. 161. Relates to dependent and delinquent children and would create the office of state probation officer and prescribe the duties thereof.

H. 276. Requiring the certification and recordation of proceedings of hearings on insanity and feeblemindedness.

H. 310. Providing for mental and physical examinations by competent physicians of persons committed to state correctional institutions.

Massachusetts

S. 169. Requiring certain physical and mental examinations of applicants for licenses to operate motor vehicles.

S. 172. Providing for reëxamination of operators of motor vehicles to determine their fitness to operate such vehicles.

Michigan

H. J. R. 5. Providing a jury trial when insanity is used as a defense for crime.

H. 78. Providing that persons certified insane by physicians may be detained for examination and observation for a period not to exceed five days.

H. 109. Providing that insane convicts, sentenced for any felony, can be imprisoned in criminal insane asylums.

S. J. R. 6. Proposing an amendment to the State Constitution authorizing the state to borrow money to be used for the purpose of building hospitals and asylums for the insane and other institutions.

S. 146. Would make incurable insanity ground for divorce.

Minnesota

H. 783. Authorizing the guardian of an insane person to prosecute actions for divorce.

H. 818 and S. 790. Would establish a state hospital for the dangerous insane and provide for the transfer of such patients from the state insane, penal, and reformatory institutions.

H. 842 and S. 639. Would appropriate money for additions to, enlargement of, and equipment for the asylum for the dangerous insane at St. Peter.

H. 954 and S. 1147. Providing for the guardianship of incompetent veterans, etc. (Same as Connecticut H. 295.)

S. 420. Would provide for the construction and maintenance of a psychopathic hospital at the state university and appropriate $260,000 therefor.

Doctor Southard and "Social Psychiatry"

The *Journal of Juvenile Research* for July contains a full bibliography of the writings of Dr. Elmer Ernest Southard. One hundred and eighty publications are listed in chronological order, showing, as a postscript points out, the trend of Doctor Southard's interest away from purely medical subjects toward studies of psychological and social significance.

An appreciation of Dr. Southard by Dr. William Healy appears in the same number of the *Journal* and Dr. Norman Fenton, director of the California Bureau of Juvenile Research and editor of the *Journal*, contributes the following note on the development of the terms "social psychiatry" and "psychiatric social work" by Dr. Southard and Miss Mary C. Jarrett.

"The origination and definition of new terms are frequently sources of new insight into perplexing problems. This is especially true of concepts used for the description of the interrelationship of human nature and the social order. The term *social psychiatry* was first used by Dr. Southard in an article published in July, 1918. Therein he said, 'I have recently given two sets of lectures to social workers on what I termed "social psychiatry".'[1] Mary C. Jarrett, chief of social service at the Boston Psychopathic Hospital, had previously suggested another related term, 'psychiatric social work'.[2] In *The Kingdom of Evils* (the first textbook in social psychiatry) Southard and Jarrett said, 'We claim no novelty or originality for the

[1] See *Mental Hygiene and Social Work.* Mental Hygiene, Vol. 2, July, 1918, p. 343. Jarrett had used the term earlier in the following quotation: "Dr. Southard, Director of the Boston Psychopathic Hospital, thinks that before long there will be a branch of psychiatry known as social psychiatry, exactly as definite in its way as social psychology." *Medicine and Surgery,* Vol. 11, September, 1917, p. 736.

[2] The first use of the term "psychiatric social work" in published work was by Southard in his annual report as director of the Boston Psychopathic Hospital, 1917, p. 49. Jarrett first used the term in an article entitled *Psychiatric Social Work.* Mental Hygiene, Vol. 2, April, 1918, pp. 283–90.

social work of the Psychopathic Hospital, but rather, we would claim to have created *the part that the social worker is to play in the mental-hygiene movement* and to have given it a name—*psychiatric social work.*' [1]

'' The definition of 'social psychiatry' was a problem which Southard was approaching from several angles with the caution and circumspection of a well-versed logician. A number of articles illustrate the struggle to delimit a term which may actually be too broad for any definition short of an entire textbook. This is virtually what Southard and Jarrett attempted later.[2] In the following quotation they discussed definition, but only in a negative sense, in emphasizing to the reader what 'social psychiatry' is not. 'To avoid confusion of terms, it may be well to state here that *''social psychiatry''* is not used as an alternate for *''psychiatric social work''*. Psychiatric social work is the special form of social work in which psychiatric knowledge is particularly required. Social psychiatry is an art now in the course of development by which the psychiatrist deals with social problems. Social psychiatry is a branch of psychiatry and a special kind of medical art. That part of the knowledge which has a bearing upon social problems is given to social workers in courses named social psychiatry—that is, the essentials of psychiatry from the standpoint of social work. The special preparation of the psychiatric social worker should consist not only of courses in social psychiatry, but also of practice in social work with psychiatric cases. The inclusive term mental hygiene is used to cover the activities of psychiatrist, psychologist, and the psychiatric social worker in promoting mental health wheresoever.' [3]

''It may seem to some that the discovery of new terms is an enjoyable pastime rather than productive scholarship. Certainly any one who knew Dr. Southard intimately is well aware of the joy he found in the creation of new terms. In fact, philology itself was an eminent interest of his. As an accompaniment of the proceedings of the staff conference or clinic at the Boston Psychopathic Hospital, he usually had some lexicon open before him, a Greek one was his favorite. Not a word of the case escaped him, the patient's interests were given all due consideration, but the final summary of the case, in addition to satisfactory medical and social suggestions, contained a brilliant embellishment of exact philological analysis. The extent of his interest in philology is illustrated by the following incident. I once sent him a French-Italian-Spanish grammar printed in 1580, picked up in a bookstall in Neufchateau, thinking he would appreciate it as an

[1] *The Kingdom of Evils*, by E. E. Southard, M.D., and M. C. Jarrett. New York: The Macmillan Company, 1922. p. 521.

[2] In *The Kingdom of Evils.*

[3] *Ibid.*, pp. 523–24.

antique. Dr. Southard wrote in reply that he was especially glad to have it as it was just in line with some work he was then doing! He was, indeed, vitally concerned with the insight into human nature obtained from comparative philology, and once stated that 'human facts are got at more readily in linguistics and in psychopathology than in logic and the so-called normal psychology'.[1]

"Actually, a new scientific term is extremely valuable. There is something of an analogy in the business world wherein great bonuses are paid for new slogans. The use by Dr. Adolf Meyer of the term 'mental hygiene' in naming a great national organization for human betterment,[2] and by Southard and Jarrett of 'psychiatric social worker' were important contributions to psychiatry. The term 'social psychiatry' is virtually a challenge to the profession in definition, a challenge which Dr. Southard, had he lived, would no doubt shortly have met successfully.

"Every science needs a good philologist to keep it logical and orderly in its acceptance of new terminology, and to suggest more illuminating names for familiar concepts. Psychiatry is indebted to Dr. Southard for the stimulating term 'social psychiatry' and for his help in the popularization of the appropriate term 'psychiatric social work'. The second is an accepted commonplace to-day. With regard to the first, it is relevant and interesting to quote Dr. Southard's own reaction to another important term in psychiatry: 'The term mental hygiene itself, one had to maintain with social workers, was a good term. Even its apparent vices could be shown to be merely unevolved virtues.'[3]

"To-day, when narrow and intensive scholarship, perhaps of necessity, is the usual mode of scientific workers, it is indeed a rare privilege to think back to a friendship with Southard, whose breadth of interest suggested the Aristotelian tradition and whose joy in learning and teaching revealed an exuberance of spirit beyond that of ordinary men."

A Behavior Clinic for Tuberculous Children

The first clinic for behavior problems in a hospital for tuberculous children was recently established at Sea View Hospital, Staten Island, New York. The clinic was instituted in response to the need for a means of handling the behavior disturbances that result from subjecting children to a strict routine with enforced inactivity over long periods of time. Its personnel, all of whom worked voluntarily, con-

[1] *Philosophical Review*, Vol. 25, May, 1916, pp. 424–25.

[2] The term was first used by Isaac Ray in 1863 as the title of a book. The organization referred to here is The National Committee for Mental Hygiene.

[3] *Mental Hygiene and Social Work*, p. 397.

sisted of Dr. John Levy, psychiatrist, and Drs. A. Courthial and Ruth Crawford, psychologists. A member of the staff of Sea View Hospital, Miss M. White, served as social worker, effecting a liaison between clinic and hospital.

The clinic has been held one afternoon every week. Each case referred to it is given a mental test and a psychiatric examination, and a psychiatric history is secured. On the basis of the information obtained from these sources, treatment is outlined and discussed with the nurse in charge of the ward. A follow-up of each case is made almost every week to determine progress and to change the treatment when necessary.

With the coöperation of the occupational-therapy department of the hospital, two periods of occupational therapy were instituted for the children studied at the clinic. These classes have been a valuable adjunct to the clinic's work and it is hoped that they may be extended to cover more periods.

The clinic has also undertaken a mental-health survey of all the children in the hospital, with the twofold purpose of bringing to light problem children who would not otherwise be reached and giving the staff some idea as to the prevalence of behavior problems and their relationship to other problems, as well as providing data on the influence of confinement and rigid routine upon behavior. Only one ward had been surveyed at the time the clinic closed for the summer, but the results were interesting enough to justify a continuation of the study.

During the coming year the clinic hopes to establish a nursery-school routine for the youngest children. The difficulty here is to secure trained personnel to serve without pay, but an effort is being made to interest outside students in the project and help has been promised.

In the report submitted at the close of the clinic's first three months of operation, Dr. Levy has several recommendations to offer. One is that a course of lectures or talks be instituted for the personnel of the hospital with the aim of giving them a better understanding of the readjustment required of the child patient—picked up from the activity of the city streets and carried away from home to an enforced inactivity and confinement, the reason for which he comprehends but dimly, if at all. The tactful, patient handling that children in this situation need is not always forthcoming, and many of their difficulties can be traced to this source.

Lack of recreational opportunities is another source of behavior difficulties, and Dr. Levy suggests the use of such forms of passive recreation as radios, victrolas, quiet games, and reading aloud, the last under the supervision of a visiting committee whose function it would be to provide reading material and volunteers to read to the

children. He further suggests that a teacher might be detailed to carry on instruction in the ward. The nurses have not time for these extra activities.

Another suggestion is that the children's wards be decorated a little more gaily. A cheerful atmosphere, Dr. Levy feels, would contribute to the hopefulness and optimism of the children's attitude and perhaps indirectly to the improvement of their physical condition.

His final recommendation is that a special social worker be secured, as the increasing work of the clinic is too much for a member of the hospital staff to carry in addition to her regular duties. A social worker connected with the clinic could do valuable follow-up work in the community after the children have left the hospital, and might also make possible an extension of the mental-hygiene approach to the adult service.

PROCEEDINGS OF THE FIRST COLLIQUIUM ON PERSONALITY INVESTIGATION

The Committee on Relations with the Social Sciences, of the American Psychiatric Association, has recently issued in book form the Proceedings of the First Colloquium on Personality Investigation, held in New York City, December 1–2, 1928. The committee, which consists of five members—Dr. William A. White, Dr. George M. Kline, Dr. Arthur H. Ruggles, Dr. Edward A. Kempf, and Dr. Harry Stack Sullivan—was created at the Eighty-third Annual Meeting of the American Psychiatric Association in 1927, its purpose being to "survey the field of interrelations of psychiatry and the social sciences, with view to greater coöperation among those concerned in studying the nature and influence of cultural environments".

After a preliminary survey, the committee invited a number of well-known representatives of psychiatry and the social sciences to take part in an informal discussion, with the idea of trying to find some common meeting ground and to determine what contribution each science could make to the solution of social problems. Those who finally participated in the discussion were F. H. Allport, of Syracuse University; G. W. Allport, of Dartmouth College; E. W. Burgess, F. E. Knight, R. E. Park, Edward Sapir, and L. L. Thurstone, of the University of Chicago; Z. C. Dickinson, of the University of Michigan; George Draper of the Columbia-Presbyterian Medical Center; L. K. Frank and Leonard Outhwaite, of the Laura Spelman Rockefeller Memorial; Sheldon Glueck and Elton Mayo, of Harvard University; E. R. Groves, of the University of North Carolina; William Healy, of the Judge Baker Foundation; M. A. May, of Yale University; Samuel Orton, of the American Psychiatric Association; G. E. Partridge, of Sheppard and Enoch Pratt Hospital;

C. R. Shaw, of the Institute for Juvenile Research; William I. Thomas, of the New School for Social Research; and Kimball Young, of the University of Wisconsin. The Committee was represented by Drs. White, Ruggles, and Sullivan. The Social Science Research Council, The Bureau of Social Hygiene, The Rockefeller Foundation, and the Russell Sage Foundation also had representatives present.

The informal nature of the colloquium permitted of an interplay of ideas and a freedom of expression that give an unusual quality of freshness and spontaneity to the published proceedings. Psychiatrists, psychologists, sociologists, and all others who have to do with social problems will find the discussion of interest, not only for its subject-matter—its wide range and the variety of stimulating points of view presented—but as a sign of the times, an indication of a movement toward closer collaboration between the various sciences that deal with human behavior.

Copies of the Proceedings can be obtained from the secretary of the committee, Dr. Harry Stack Sullivan, P. O. Box 1, Towson, Maryland. The price is sixty cents for paper-bound copies, one dollar for cloth-bound.

What Is Obscenity?

Editorial, *Journal of Social Hygiene*

In the present chaotic situation, the United States "obscenity" law is more apt to be a boomerang than a sword of justice. Its lack of adequate definition serves to confuse judges and to make bewildered juries the interpreters of sound educational and scientific procedures, a task for which they usually are wholly untrained. They are faced with simple dictionary words widely used in educational circles of to-day, but words which their generation largely omitted from its vocabularies because of an age-old taboo against the discussion of problems relating to sex. They mistrust these terms and may be easily inclined to adjudge them obscene, thereby penalizing authors and publishers who seek to aid in the elimination of the old trial-and-error methods of youth training.

Attempts by judges to define obscenity have resulted, to date, in confusion worse confounded, in that the offense, as legally described, consists in the circulation of literature which stimulates lewd and lascivious thoughts in the minds of susceptible persons. Neither the law nor existing definitions furnish a definite guide as to what thoughts are lewd and lascivious or what persons are susceptible to them. The most that jurors can do, therefore, is to formulate their own standards. These, of necessity, will be colored by the emotions and

prejudices of the composite collection of individuals selected to serve as arbiters of fact, and by the judge's rulings and charge. Out of such ill-assorted and unstable threads is our present fabric of obscenity decisions loomed.

There seems to be but little if any disagreement on the value of legislation penalizing those who exploit obviously indecent materials—such, for instance, as the lewd "for men only" films and shows, pornographic pictures and postal cards, and the smut type of literature plainly indicating its perversive character and distributed through bootleg channels. Internationally, the League of Nations has given cognizance to the importance of this work by sponsoring an International Convention which has been signed by a number of important countries, and by assigning to a special committee the task of studying it. In the United States and some other countries, official law-enforcement machinery and voluntary agencies have done yeoman service in suppressing these undoubted evils and the public have supported them in their work. When, however, these agencies run amuck in the no-man's land of opportunist censorship, they quickly are confronted with questions and conditions that require sound and careful consideration rather than summary action. How can we expect this studious and, necessarily, tolerant attitude from a jury too often chosen by a series of questions calculated to prove that they are unfamiliar with the points at issue and unread in the literature of the field involved?

Surely the present obscenity law is an impotent measure to deal fairly with the genuine literary and educational books and pamphlets. "Literary, like other nuisances, should not be committed", says *The London Mercury*, but this law does not ensure the needed reasonable censorship by proper authority which many would welcome. Its lack of clarity and the uncertainties of its application jeopardize much of the most valuable material now available for the fine, socializing, character-training educational efforts that are making such notable progress in home, school, and church.

Cato, hewing to the line "*Carthago delenda est*", greatly aided the destruction of Rome's most formidable enemy. It may be that a similar result can be achieved here if we constantly remind our neighbors and selves that the obscenity law must be changed, and that its enforcement must be limited to cases which are clearly violations of the intent and purpose of the law.

It is encouraging to note that already legislators are endeavoring to remedy the situation and to clear up the vexing inconsistencies which arise to plague all, not only those who administer the law, but those who wish to live up to it.

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M. THÉRÈSE DE BERMINGHAM

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KATHLEEN ORMSBY LARKIN, Educational Assistant

GENERAL PURPOSES

The National Committee for Mental Hygiene, directly and through its affiliated state societies and local committees, works for the conservation of mental health; the reduction and prevention of mental and nervous disorders and defects; the improved care and treatment of those suffering from mental diseases; the special training and supervision of the feebleminded; and the acquisition and dissemination of reliable information on these subjects and on mental factors involved in the problems of education, industry, delinquency, dependency, and others related to the broad field of human behavior. The committee seeks to accomplish its purposes by stimulating research into the nature and causes of nervous and mental diseases and defects; conducting surveys and studies of mental-hygiene problems; applying the knowledge gained from such studies, through education and the promotion of beneficial legislation; encouraging psychiatric social work; establishing child-guidance and other mental-hygiene clinics; developing trained personnel; and coöperating with governmental and unofficial agencies whose work touches at any point the field of mental hygiene.

When one considers the large groups of people who may be benefited by organized work in mental hygiene, the importance of the movement at once becomes apparent. Such work is not only for the mentally disordered and those suffering from mental defect, but for all those who, through mental causes, are unable so to adjust themselves to their environment as to live happy and efficient lives.